Oregon
Theodore R. Kulongoski, Governor

**Department of Human Services**
**Health Services**

*Office of Medical Assistance Programs*
Salem, OR 97301-1077
Voice (503) 945-5772
FAX (503) 373-7689
TTY (503) 378-6791

July 2004

To: OMAP Service Providers

From: Joan Kapowich, Manager
OMAP Program and Policy

Re: General Rules Program, Rulebook Revision 5

Effective: **August 1, 2004 (corrected 8-3-04)**

OMAP updated the General Rules Program Rulebook as follows:

OMAP amended 410-120-1210 and 410-120-1230 to implement modifications to the Oregon Health Plan (OHP) Standard Benefit Package as directed by the 2003 Legislative Assembly in HB 2511. Some benefits are restored while other benefits are removed. Implementation of these amendments is approved by the Centers for Medicare and Medicaid Services (CMS).

- If you are reading this letter on OMAP's website: (http://www.dhs.state.or.us/policy/healthplan/rules/), this Administrative rulebook contains a complete set of rules for this program, including the above revisions.

- If you receive hardcopy of revisions, this letter is attached to the revised rules to be used as replacements in your rulebook. Each rule is numbered individually for easy replacement.

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

TR 545 8/1/04

DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

# DIVISION 120

# GENERAL RULES


410-120-0000 Definitions

410-120-0250 Managed Care Organizations

410-120-1140 Verification of Eligibility

410-120-1160 Medical Assistance Benefits and Provider Guides

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

410-120-1190 Medically Needy Benefit Program

410-120-1195 SB 5548 Population

***Table 120-1195 – SB 5548 Prescription Drug List***

410-120-1200 Excluded Services and Limitations

410-120-1210 Medical Assistance Benefit Packages and Delivery System:

410-120-1230 Client Copayment

***Table 120-1230-1***

410-120-1260 Provider Enrollment

410-120-1280 Billing

***Table 1280 Third Party Resource (TPR) Explanation Codes***

410-120-1290 Labor and Delivery Out of Managed Care Organizations Service Area

410-120-1295 Non-Participating Provider

410-120-1300 Timely Submission of Claims

410-120-1320 Authorization of Payment

410-120-1340 Payment

410-120-1350 Buying-Up

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

410-120-1380 Compliance with Federal and State Statutes

410-120-1385 Compliance with Public Meetings Law

410-120-1390 Sponsorships

410-120-1400 Provider Sanctions

410-120-1420 Basis for Mandatory Sanctions

410-120-1440 Basis for Discretionary Sanctions

410-120-1460 Type, Duration, and Determination of Sanction

410-120-1480 Notice of Immediate, Proposed and Final Sanctions

410-120-1500 Additional Remedy and Other Provisions

410-120-1520 Denial or Recovery of Reimbursement Resulting from Medical Review

410-120-1540 Recovery of Overpayments to Providers resulting from medical review/audit

410-120-1560 Provider Appeals

410-120-1565 Provider Appeals -- Appeal of Payment/Sanction Decisions

410-120-1570 Provider Appeals (Level 1) - Claims Reconsideration

410-120-1580 Provider Appeals (Level 2)-- Administrative Review

410-120-1600 Provider Appeals (Level 3) - Contested Case Hearings

410-120-1640 Provider Appeals - Contested Case Hearing Definitions

410-120-1660 Provider Appeals -- Contested Case Hearing Request

410-120-1680 Provider Appeals - Contested Case Pre-Hearing Conference

410-120-1685 Recovery of Overpayments to Providers - Recoupments and Refunds

410-120-1700 Provider Appeals -- Proposed and Final Orders

410-120-1720 Provider Appeals -- Hearing Evidence

410-120-1820 Provider Hearings -- Hearing Attendance

410-120-1860 Client Appeals

410-120-1865 Denial, Reduction, or Termination of Services

410-120-1870 Client Premium Payments

410-120-1875 Agency Hearing Representatives

410-120-1880 Contracted Services

410-120-1920 Institutional Reimbursement Changes

410-120-1940 Interest Payments on Overdue Claims

410-120-1960 Payment of Private Insurance Premiums

410-120-1980 Requests for Information and Public Records

**410-120-0000 Definitions**

(1) AAA -- Area Agency on Aging.

(2) Acupuncturist -- A person licensed to practice acupuncture by the (3) Acupuncture Services --Services provided by a licensed Acupuncturist within the scope of practice as defined under state law.

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

(5) 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.

(6) Adequate Record Keeping-- Documentation that supports the level of service billed. See410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules .

(7) Administrative Medical Examinations and Reports -- Examinations, evaluations, and reports, including copies of medical records, requested on the OMAP 729 form through the local CAF, SPD, OMHAS branch office or requested and/or approved by OMAP to establish client eligibility for a medical assistance program or for casework planning.

(8) 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 Pharmaceutical Services and the Home Enteral/Parenteral Nutrition and IV Services provider rules, except as specified in OAR 410-120-1340, Payment.

(9) Ambulance -- A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Health Division of the Department of Human Services or the licensing standards of the state in which the provider is located.

(10) Ambulatory Surgical Center (ASC) -- A facility licensed as an ASC by the Department of Human Services.

(11) American Indian/Alaska Native clinic -- Clinics recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid (CMS).

(12) 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).

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

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

(15) 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.

(16) Automated Information System (AIS) -- A computer system that provides information on clients' current eligibility status under the Medical Assistance Program.

(17) Benefit Package – The "package" of covered health care services for which the client is eligible.

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

(19) Buying Up -- The practice of obtaining client payment in addition to the OMAP or managed care plan payment to obtain a non-covered service or item. For example, an additional client payment to obtain a gold crown (not covered) instead of the stainless steel crown (covered); an additional client payment to obtain eyeglass frames not on the OMAP or plan contract. If a

client wants to purchase a non-covered service or item, they must be responsible for full payment. OMAP or plan payment for a covered service cannot be credited toward the non-covered service.

(20) 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.

(21) Children, Adults and Families (CAF) – a Division of the Oregon Department of Human Services, responsible for administering self-sufficiency and child-protective programs;

(22) Children's Health Insurance Program (CHIP) -- A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by the Department of Human Services Office of Medical Assistance Programs (see Medical Assistance Program).

(23) Chiropractor -- A person licensed to practice chiropractic by the relevant State Licensing Board.

(24) Chiropractic Services-- Services provided by a licensed Chiropractor within the scope of practice, as defined under State law and Federal regulation.

(25) 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 is defined in OAR 410-120-1200 (2)(b)(F).

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

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

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

(29) Contiguous Area Provider -- A provider practicing in a contiguous area.

(30) Copayments -- The portion of a claim or medical 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.

(31) Cost Effective -- The lowest cost health care service or item which, in the judgment of Medical Assistance Program staff, meets the medical needs of the client.

(32) Current Dental Terminology (CDT) -- A listing of descriptive terms identifying dental procedure codes used by the American Dental Association in theCDT-3.

(33) Current Procedural Terminology (CPT) -- The Physicians' Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(34) Date of Receipt of a Claim -- The date on which OMAP 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 Internal Control Number (ICN).

(35) 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.

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

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

(38) 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.

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

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

(41) Department of Human Services (DHS) -- The Oregon Department of Human Services or any of its divisions, programs, or offices.

(42) Diagnosis Code -- As identified in the ICD-CM, the primary diagnosis code is shown in all billing claims, unless specifically excluded in an individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(43) Disability Services Office (DSO) -- Disability Services Office. A branch of Seniors and People with Disabilities Division.

(44) Division -- The Office of Medical Assistance Programs of the Department of Human Services.

(45) Division Representative -- A person who represents the Division in the hearing and presents the Division's position.

(46) Durable Medical Equipment and Supplies (DME) -- 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.

(47) Electronic Eligibility Verification Service (EEVS) -- Vendors of medical assistance eligibility information that have met the legal and technical

specifications of OMAP in order to offer eligibility information to enrolled providers of OMAP.

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

(49) Emergency Medical Services -- The health care and services provided for diagnosis and treatment of 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 both the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. If an emergency medical condition is found to exist, emergency medical services necessary to stabilize the condition must be provided. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

(50) Emergency Transportation -- Transportation necessary when a sudden, unexpected occurrence creates a medical crisis requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(51) EOB -- Explanation of Benefits.

(52) EPSDT (Medicheck) --The Title XIX program of Early and Periodic Screening, Diagnosis and Treatment 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 Medical Assistance Program recipients and their parents or guardians effectively use them.

(53) False Claim -- A claim that a provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and such

inaccurate or misleading information would result, or has resulted, in an overpayment.

(54) Family Planning --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.

(55) 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 the Centers for Medicare and Medicaid upon recommendation of the U.S. Public Health Service.

(56) Fee-for-Service Provider -- A medical provider who is not reimbursed under the terms of an OMAP contract with a Prepaid Health Plan. A medical provider participating in a Prepaid Health Plan may be considered a Fee-for-Service provider when treating clients who are not enrolled in a Prepaid Health Plan.

(57) General Assistance (GA) -- Medical Assistance administered and funded 100% with State of Oregon funds through the Oregon Health Plan.

(58) HCPCS -- Healthcare Common Procedure Coding System, 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. The Medical Assistance Program (OMAP) uses HCPCS codes; however, OMAP uses current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(59) 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.

(60) 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.

(61) 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 provider rules.

(62) 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 the Oregon State Health Division as a home health agency in Oregon, and meets the surety bond and capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(63) 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.

(64) Home Intravenous (IV) 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 rules.

(65) 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 rules.

(66) Hospital -- A facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in the Medical Assistance Program under Title XVIII of the Social Security Act. Facilities licensed as Special Inpatient Care Facilities under the Office of Public Health System’s definition of hospital are not considered hospitals by OMAP for reimbursement purposes; however, effective April 1, 2000,OMAP will reimburse a Special Inpatient Care Facility if the Centers for Medicare and Medicaid has certified the facility for participation in the

Medicare Program as a hospital. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as an 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.

(67) 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" (OMAP 42) report for the Office of Medical Assistance Programs.

(68) 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 the Medical Assistance Program.

(69) ICD-9-CM -- The ninth revision of the International Classification of Diseases Clinical Modification, including volumes 1, 2, and 3, as revised annually.

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

(71) Inpatient Hospital Services -- Services that are furnished in a hospital for the care and treatment of an inpatient. (See Hospital Services rules for definition of an inpatient.)

(72) Institution for Mental Diseases (IMD) -- An institution whose overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases. The following guidelines are used to assist in determining whether an institution is an IMD. No single guideline is necessarily determinative:

(a) The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases and/or alcohol and/or drug abuse problems;

(b) The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases and/or alcohol and/or drug abuse problems;

(c) The facility is accredited as a psychiatric facility by the JCAHO or is licensed by the Office of Public Health Systems as a facility for the treatment of alcohol and drug abuse problems;

(d) The facility specializes in providing psychiatric/psychological care and treatment and/or rehabilitative treatment for alcohol and/or drug abuse problems;

(e) The facility is under the jurisdiction of the State's Office of Mental Health and Addiction Services Division;

(f) More than 50 percent of all the patients in the facility are being treated for mental diseases and/or alcohol and/or drug abuse problems;

(g) A large proportion of the patients in the facility have been transferred from a State mental institution for continuing treatment of their mental disorders;

(h) Independent review teams report a preponderance of mental illness and/or drug and alcohol abuse diagnoses for the patients in the facility;

(i) Part or all of the facility consists of locked wards.

(73) 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. (Example: If the SSI monthly payment amount were $434.00,the ILIS would be $1,302.) This is the standard used to calculate eligibility for long-term nursing care in a Nursing Home or eligibility for services under SPDs Home and Community Based Waiver.

(74) 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.

(75) Laboratory – A facility licensed under ORS 438 and certified by the Centers for Medicare and Medicaid, DHHS, as qualified to participate under Medicare, to provide laboratory services within or a part from a hospital. An entity is considered a laboratory if materials are 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. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered under the Clinical Laboratory Improvement Act (CLIA), to be a laboratory.

(76) 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.

(77) Licensed Direct Entry Midwife -- A practitioner licensed by the Oregon Health Division as a Licensed Direct Entry Midwife.

(78) 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, homeowners '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.

(79) 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 Medical-Surgical Services rules.

(80) Medicaid -- A Federal and State funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Department of Human Services (see Medical Assistance Program).

(81) Medical Assistance Program -- A program for payment of health care provided to eligible Oregonians. Oregon's medical assistance program includes Medicaid Services, including the OHP Medicaid demonstration, and the Children's Health Insurance Program (CHIP):

(a) The Medical Assistance Program is administered by identified Divisions, and the Office of Medical Assistance Programs (OMAP), of the Department of Human Services;

(b) Coordination of the Medical Assistance Program is the responsibility of the Office of Medical Assistance Programs (OMAP).

(82) Medical Assistance Eligibility Confirmation -- Verification through AIS, AIS Hot-Line, an authorized DHS representative, or through presentation of a valid Medical Care Identification that a client has an open assistance case, which includes medical benefits.

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

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

(85) 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 and professional standards of care as effective;

(c) Not solely for the convenience of an Oregon Health Plan 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 OMAP Member or PCCM Member in the PHP's or Primary Care Case Manager's judgement.

(86) 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.

(87) Medicheck for Children and Teens -- See EPSDT.

(88) MSO – Multiple Services Office. A branch of the Seniors and People with Disabilities Division.

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

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

(91) "Not Covered Services"-- Services or items for which the Medical Assistance Program is not responsible for payment. Not-covered services are identified in:

(a) OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations; and,

(b) 410-141-0480, Benefit Package of Covered Services;

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

(d) The individual OMAP provider rules.

(92) 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.

(93) 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.

(94) 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.

(95) Nursing Facility – A facility licensed and certified by the Senior and Disabled Services Division as defined in 411-070-0005.

(96) 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.

(97) 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.

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

(99) 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.

(100) Office of Mental Health and Addiction Services -- An Office within the Oregon Department of Human Services.

(101) (The) Office of Medical Assistance Programs (OMAP) -- An Office of the Oregon Department of Human Services. OMAP is responsible for coordinating the Medical Assistance Program within the State of Oregon.

(102) OMAP-- Office of Medical Assistance Programs (see Medical Assistance Programs).

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

(104) Optometrist – A person licensed to practice optometry pursuant to State law.

(105) Oregon Medical Professional Review Organization (OMPRO) -- OMPRO is the Oregon Professional Review Organization for Medicare and contracts with OMAP to provide hospital utilization review and other services for the Medical Assistance Program. A Professional Review Organization is an organization established under federal law by the Department of Health and Human Services for the purpose of utilization review and quality assurance.

(106) Oregon Youth Authority -- 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.

(107) Out-of-State Providers -- Any provider located outside the borders of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of Oregon.

(108) Outpatient Hospital Services -- Services that are furnished in a hospital for the care and treatment of an outpatient. See Hospital Services rules for definition of outpatient.

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

(110) Overpayment --Payment(s) made by the Medical Assistance Program to a provider in excess of the correct Medical Assistance Program payment amount for a service. Overpayments are subject to repayment to the Medical Assistance Program.

(111) Overuse – Use of medical goods or services at levels determined by Medical Assistance Program medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

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

(113) Payment Authorization – Authorization granted by the responsible agency, division, 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.

(114) 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.

(115) Pharmacist – A person licensed to practice pharmacy pursuant to state law.

(116) 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.

(117) Physical Therapist – A person licensed by the relevant State licensing authority to practice physical therapy.

(118) 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.

(119) 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.

(120) 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.

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

(122) Podiatric Services – Services provided within the scope of practice of podiatrists as defined under state law.

(123) Podiatrist – A person licensed to practice podiatric medicine pursuant to state law.

(124) 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.

(125) 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.

(126) 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.

(127) Primary Care Provider – 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. Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically appropriate client care.

(128) Prior Authorization (PA) – Payment authorization for specified medical services or items given by Medical Assistance Program staff prior to provision of the service. A physician referral is not a prior authorization.

(129) 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.

(130) Provider – An individual, facility, institution, corporate entity, or other organization which supplies health care services or items or bills on behalf of a provider of services. The term "provider" refers to both Performing Providers and Billing Providers unless otherwise specified. Payment can only be made to OMAP-enrolled providers, who have, by signature on the provider enrollment form, agreed to provide services and to bill in accordance with these General Rules and the individual program rules.

(131) Psychiatric Hospital – A hospital licensed by the relevant State licensing authority as a psychiatric hospital and certified as such under Title XVIII and XIX of the Social Security Act or any hospital which meets the federal definition of an Institution for Mental Disorders (IMD).

(132) Public Health Clinic – A clinic operated by county government.

(133) 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 Medical Assistance Program clients.

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

(135) Qualified Medicare and Medicaid Beneficiary (QMM) – A Medicare Beneficiary who is also eligible for Medical Assistance Program coverage.

(136) 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.

(137) Recipient – A person who is currently eligible for Medical Assistance (also known as a “client”).

(138) Recoupment – An accounts receivable system that collects money owed by the provider to the Medical Assistance Program by withholding all or a portion of a provider’s future payments.

(139) Referral – The transfer of total or specified care of a client from one provider to another. As used by OMAP, 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, or managed by a primary care physician, a referral is required before non-emergency care is covered by the health plan or the Medical Assistance Program.

(140) 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.

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

(142) Retroactive Medical Eligibility – Eligibility for Medical Assistance granted to a client retroactive to a date prior to the client’s application for Medical Assistance.

(143) Sanction – An action against providers taken by the Medical Assistance Program in cases of fraud, misuse or abuse of Medical Assistance Program requirements.

(144) 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.

(145) Senior and People with Disabilities (SPD) – A Division of the Oregon Department of Human Services responsible for the administration of programs that increase the independence of, and help protect, seniors and people with disabilities.

(146) Service Agreement -- An agreement between the Medical Assistance Program 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.

(147) 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.

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

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

(150) 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.

(151) 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.

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

(153) Subrogation – Right of the State to stand in place of the client in the collection of third party resources.

(154) 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.

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

(156) Suspension -- A sanction prohibiting a provider's participation in the Medical Assistance Program by deactivation of the provider's 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.

(157) Targeted Case Management -- Activities which 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.

(158) Termination -- A sanction prohibiting a provider's participation in the Medical Assistance Program by canceling the provider's number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Medical Assistance Program at the time of termination.

(159) 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 Medical Assistance Program client.

(160) Transportation -- See "Medical Transportation".

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

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

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

(164) 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 are to be considered.

(165) 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.

(166) Valid Claim -- An invoice received by the appropriate Division or Office of the Medical Assistance Program 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 third party; and

(b) Has been received within the time limitations prescribed in these General Rules

(167) 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
Stats. Implemented: ORS 414.065
October 1, 2003

**410-120-0250 Managed Care Organizations**

(1) Some OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Managed Care Organization (MCO). A managed care organization may be a Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO) or a Chemical Dependency Organization (CDO).

(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.

(3) Authorization criteria may vary between MCO plans. 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
October 1, 2003

**410-120-1140 Verification of Eligibility**

(1) The client's Medical Care Identification is confirmation of eligibility for medical services, subject to the limitations contained in these General Rules and the appropriate individual provider guides.

(2) It is the responsibility of the provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service for the service provided and whether a managed care plan or OMAP is responsible for reimbursement. The provider assumes full financial risk in serving a person not identified as eligible or not confirmed by the Medical Assistance Program as eligible for the service provided on the date(s) of service.

(3) A Medical Care Identification (Form OMAP 1417) or Temporary Medical Care Identification (Form OMAP 1086) is issued to the head of an eligible household or eligible individual. Both Medical Care Identifications include:

(a) The name(s) of the eligible individual(s), Social Security number, and the eligible person(s) Recipient Identification Number;

(b) The client identification (ID) number;

(c) Dates of coverage, including fee-for-service and managed care enrollment dates;

(d) The benefit package for which the client is eligible;

(e) Optional program messages (for example, third party resource (TPR) information);

(f) The dates of medical eligibility for the eligible person or persons;

(g) The name of the responsible branch, the worker's identification code and the phone number of the branch;

(h) The name and phone number of the managed care provider, if applicable;

(i) Medical Management restrictions, if applicable.

(4) The Medical Care Identification or Temporary Medical Care Identification is not transferrable, and is valid only for the individual(s) listed on the card.

(5) Eligibility is verified either:

(a) From the Medical Care Identification or Temporary Medical Care Identification which shows the dates on which the client is eligible and indicates the client's benefit package; or

(b) If a patient identifies him/herself as eligible, but does not have a valid Medical Care Identification or Temporary Medical Care Identification, the provider may either:

(A) Contact the OMAP Automated Information System (AIS) which operates 24 hours a day, to confirm eligibility. Providers who have contracted with an Electronic Eligibility Verification Service vendor can access client eligibility data 24 hours a day, 7 days a week; or

(B) Contact the local AFS or SDSD (DSO or AAA), or State Office of Services to Children and Families (SCF) (formerly known as CSD), branch office during regular working hours to confirm eligibility if the information is not available through AIS.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82, for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 43-1986(Temp), f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 53-1987, f. 10-29-87, ef. 11-1-87; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0040; Renumbered from 461-013-0103 & 461-013-0109; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93; OMAP 10, 1999, f. & cert. ef. 4-1-99; Renumbered from

410-120-0080; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00

**410-120-1160 Medical Assistance Benefits and Provider Guides**

(1) The following services are covered when medically or dentally appropriate and within the limitations established by the Medical Assistance Program and set forth in the Oregon Administrative Rules 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) Alcohol and Drug Detoxification inpatient services are covered by the Office of Medical Assistance Programs when provided in an acute care hospital and when hospitalization is considered medically appropriate;

(B) Alcohol and Drug Abuse Treatment inpatient hospital services are not covered by the Office of Medical Assistance Programs;

(C) Non-hospital Alcohol and Drug Detoxification and Treatment services are available on a residential or outpatient basis through the Office of Medical Assistance Programs. Contact the client's managed care plan, local alcohol/drug treatment provider or local publicly funded alcohol and drug abuse program for information.

(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.

OMAP may authorize services in excess of limitations established in the provider guide 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). Family planning services are services and items provided to individuals of childbearing 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. Services include annual exams, contraceptive education and counseling to address reproductive health issues, laboratory tests, radiological services, medical procedures, including birth control implants,

tubal ligation, vasectomy, and pharmaceutical supplies and devices;

(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 rules of the Mental Health and Developmental Disability Services Division and Seniors and People with Disabilities;

(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);

(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 OMAP 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 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 client's Medical Care Identification Card indicates a benefit

package that includes mental health will be based on the Prioritized List of Health Services. Other Medicaid non-OHP through as described in applicable treatment standard rules;

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

(x) Nutritional Counseling is covered, 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 room 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) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services, the Home Enteral/Parenteral Nutrition and IV Services and the Hospital Services provider rules (OAR 410 Division 121,148 and 125);

(ee) Preventive Services, as described in the Medical-Surgical Services and the Dental/Denturist Services provider rules (OAR 410 Division 130 and 123) and prevention guidelines associated with the Health Service Commission's List of Prioritized Health Services (OAR 410-141-0520);

(ff) Private Duty Nursing, as described in the Private Duty Nursing provider rules (OAR 410 Division 132);

(gg) Radiology and Imaging Services, as described in the Medical-Surgical

Services, the Hospital Services, and Dental and Denturist Services provider rules (OAR 410 Division 130,125 and 123);

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

(ii) School-Based Health Services, as described in the School-Based

Health Services provider rules (OAR 410 Division 133);

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

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

(ll) Vision Services as described in the Visual Services provider rules (OAR 410 Division 140).

(2) Other Divisions or Offices, including Vocational Rehabilitation, Mental Health and Developmental Disability Services Division, Office of Alcohol and Drug Abuse Programs, State Office for Services to Children and Families, and Seniors and People with Disabilities Services Division may offer services to Medicaid eligible clients, which are not reimbursed by or available through the Office of Medical Assistance Programs.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4/1/2004

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

(1) Out-of-state providers may enroll in the Medical Assistance Program as described in 410-120-1260, Provider Enrollment. Out-of-state providers must provide services and bill in compliance with all the rules in these General Rules and in the appropriate provider guide.

(2) Enrolled out-of-state providers are reimbursed in the same manner and at the same rates as in-state providers unless otherwise specified in the individual provider guide or by contract or Service Agreement with the individual provider.

(3) Enrolled non-contiguous, out-of-state providers will be reimbursed for covered services under any of the following conditions:

(a) The service was emergent or 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 increases the risk that treatment will become more complex or hazardous, or that there will be a substantially increased risk of the development of chronic illness;

(b) Payment for the service was authorized by the Medical Assistance Program in advance of the provision of services or was otherwise authorized in accordance with payment authorization requirements in the individual provider guide or in the General Rules;

(c) The service was authorized by an FCHP or DCO and payment to the out-of-state provider is the responsibility of the FCHP or DCO;

(d) The service is being billed for QMB deductible or co-insurance coverage.

(4) Non-emergency out-of-state services provided by a Non-contiguous enrolled provider, will be prior authorized under the following conditions:

(a) The service or item is covered by the Medical Assistance Program under the specific client's benefit package; and

(b) The service or item is not available in the State of Oregon and/or provision of the service or item by an out-of-state provider is cost effective,

as determined by OMAP (or, for those covered by a managed care plan, the plan will make that determination); and

(c) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician;

(d) If a client has FCHP coverage, the request for non-emergency services must be referred to the FCHP.

(5) Laboratory specimens sent to out-of-state independent or hospital-based laboratories are a covered service and do not require prior authorization. The laboratory must meet the same certification requirements as Oregon laboratories and must bill in accordance with Medical Assistance Program rules.

(6) No reimbursement is made for services provided to a client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) Program.

(7) All services provided by enrolled providers to children placed in foster care by Oregon's State Office for Services to Children and Families (SOSCF), placed in a subsidized adoption by Oregon's SOSCF outside the state of Oregon or in the custody of Oregon's SOSCF and traveling with the consent of SOSCF will be reimbursed within the limits described in these General Rules and in the individual provider guide. Authorization of non-emergency services by OMAP is not required except as specified in the individual provider guide.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 27-1978(Temp), f. 6-30-78, ef. 7-1-78; AFS 39-1978, f. 10-10-78, ef. 11-1-78; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0130; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for

remaining AFS branch offices; AFS 21-1985, f. 4-2-85, ef. 5-1-85; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0045 & 461-13-046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00

**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
Hist,: OMAP 2-2003, f. 1-31-03, cert. ef. 2-1-03

**410-120-1195 SB 5548 Population**

Effective for services rendered on or after January 1, 2004.

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by 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-retrovirals 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/.

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

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infectives or other prescriptions necessary for the direct support of organ transplants. Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(3) 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) SB 5548 clients will not be sent a medical ID card, however they will be sent a letter from the Department, 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) minus14% or Oregon Maximum Allowable Cost (OMAC), plus a dispensing fee of $3.50;

(c) DHS pharmacy benefits manager, First Health, 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 and 1235, Client Copayments;

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-04

**Table 120-1195 – SB 5548 Prescription Drug List**

Long-Acting Opioids:
- LA-Morphine Sulfate (generic)
- Dolophine
- Methadone (generic)
- Methadose
- Levo-Dromoran
- Levorphanol (generic)
- Kadian
- Oramorph SR
- Duragesic

Proton Pump Inhibitors:
- Protonix
- Aciphex
- Prevacid

Statins (Cholesterol lowering medications):
- Lovastatin (generic)
- Mevacor
- Pravachol

Non-Steroidal Anti-Inflammatory drugs:
- Naproxen (generic)
- Ibuprofen (generic)
- Piroxicam (generic)
- Salsalate (generic)

1-1-04

**410-120-1200 Excluded Services and Limitations**

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. No payment will be made for any expense incurred for any of the following services or items:

(1) That are not expected to significantly improve the basic health status of the client as determined by the Medical Assistance Program (e.g., OMAP's Medical Director, medical consultants, dental consultants or Peer Review Organization).

(2) That are not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury.

(3) That are determined not medically or dentally appropriate by Medical Assistance Program staff or authorized representatives, including OMPRO or any contracted utilization review organization.

(4) That are not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his/her scope of practice or licensure.

(5) That are 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.

(6) That are provided by friends or relatives of eligible clients or members of his/her household, except when the friend, relative or household member is a health professional, acting in a professional capacity, or when the friend, relative or household member is directly employed by the client under Seniors & People with Disabilities (SPD) Home and Community Based Waiver.

(7) That are 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 the Medical Assistance Program.

(8) Where the need for purchase, repair or replacement of materials or equipment is caused by adverse actions of clients to personally owned goods or equipment or to items or equipment rented or purchased by the Medical Assistance Program.

(9) That are related to a non-covered service; some exceptions are

identified in the individual provider rules. If the provision of a service related to a non-covered service is determined by OMAP to be cost-effective, the related medical service may, at OMAP's discretion and with OMAP's prior authorization, be covered.

(10) Which are considered experimental or investigational or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy.

(11) That are identified in the provider guide appropriate Administrative Rules, including the Hospital guide, Revenue Codes Section, as not covered.

(12) That are requested by or for a client who has been determined by the Medical Assistance Program to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services.

(13) That are for copying or preparing records or documents excepting those Administrative Medical Reports requested by the branch offices or OMAP for casework planning or eligibility determinations.

(14) Whose primary intent is to improve appearance.

(15) Which are similar or identical to services or items which 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.

(16) For the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence, except as specified by the Prioritized List of Health Services (OAR 410-141-0520).

(17) Items or services which are for the convenience of the client and are not medically or dentally appropriate.

(18) 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.

(19) Educational or training classes which are not medically appropriate (Lamaze classes, for example).

(20) Outpatient social services except Maternity Case Management

services and other social services described in the individual provider rules as covered.

(21) Plasma infusions for treatment of Multiple Sclerosis.

(22) Post-mortem exams or burial costs, or other services subsequent to the death of a client.

(23) Radial keratotomies.

(24) Recreational therapy.

(25) Telephone calls, including but not limited to telephone conferences between physicians or between a physician or other practitioner and a client or representative of the client, except for telephone calls for the purpose of tobacco cessation counseling, as described in OAR 410-130-0190, and Maternity Case Management as described in OAR 410-130-0587.

(26) Transsexual surgery or any related services or items.

(27) 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.

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

(29) Immunizations prescribed for foreign travel.

(30) Services which 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).

(31) DUII-related services already covered by the Intoxicated Driver

Program Fund as directed by ORS 813.270(1) and (5).

(32) For transportation to meet a client's personal choice of a provider.

(33) Pain center evaluation and treatment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
4-1-04

**410-120-1210 Medical Assistance Benefit Packages and Delivery System:**

(1) Clients in some Medical Assistance Program categories 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) Names of the OMAP benefit packages, effective February 1, 2003, and the recipients eligible to receive the various packages, are identified as follows:

(a) OHP Plus: The Oregon Health Plan (OHP) Plus benefit package is available to clients who 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 mandatory, selected, optional Medicaid program or the Children's Health Insurance Program and is also within the income and other eligibility criteria adopted by the Department of Human Services (DHS);

(b) OHP Standard: The OHP Standard benefit package is available to clients eligible for OHP through the Medicaid expansion waiver granted on October 15, 2002. These recipients are adults and childless couples who are also within the income and other eligibility criteria adopted by DHS. The Department identifies these clients through the program acronym, OHP-OPU;

(c) Qualified Medicare Beneficiary (QMB)-Only: QMB-Only clients are Medicare beneficiaries who have limited income but do not meet the income standard for full Medical Assistance Program coverage. QMB clients have coverage through Medicare Parts A and B for most covered services;

(d) Qualified Medicare Beneficiary (QMB) + OHP Plus: Clients covered by the QMB-OHP Plus benefit package are Medicare beneficiaries that have met the income standard for full Medical Assistance Program coverage;

(e) The Citizen/Alien-Waived Emergency Medical (CAWEM). CAWEM clients are certain eligible, non-qualified aliens that are not eligible for other

Medicaid programs pursuant to OAR 461-135-1070. The Medical Care ID that the client is issued indicates coverage. The CAWEM Benefit Package is limited to services listed in OAR 410-120-1210 (3)(e).

(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 coverage includes:

(A) Services above the funding line on the HSC prioritized list, (OAR 410-141-0520);

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

(C) Chemical dependency services provided through local alcohol/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 OMAP Members 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 the Fully Capitated Health Plan for clients enrolled in managed care;

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

(b) 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 410-141-0520);

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

(iii) Outpatient chemical dependency services provided through local alcohol/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 OMAP Members 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 for clients enrolled in managed care.

(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 OMAP program administrative rules.

(C) The following services are not covered under the 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) Visual 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 OMAP program administrative rules.

(c) 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) QMB clients may be billed by the provider for services that are not covered by Medicare. QMB clients may not be billed by the provider for the

deductible and coinsurance amounts due for services that are covered by Medicare.

(d) QMB + OHP Plus Benefit Package coverage includes any service covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible. This package also covers:

(A) Services above the funding line on the HSC prioritized list, (OAR 410-141-0520);

(B) Mental health services;

(C) Chemical dependency services provided through a local alcohol/drug treatment provider.

(e) Citizen/Alien-Waived Emergency Medical Assistance (CAWEM) Benefit Package services are limited to:

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

(B) 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 room/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) OMAP 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) The name and phone number of the PHP appears on the Medical Care Identification.

(b) Primary Care Managers:

(A) These clients are enrolled with a Primary Care Manager (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 OMAP-enrolled provider that accepts FFS clients. The provider will bill OMAP directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
8-1-04

**410-120-1230 Client Copayment**

(1) OHP Plus clients shall be responsible for paying a copayment for some services. This copayment shall be paid directly to the provider.

(2) The following services are exempt from copayment:

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

(b) Family planning services and supplies;

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

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

(3) The following clients are exempt from copayments:

(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 OMAP contracted Prepaid Health Plan (PHP) will be exempt from copayments 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 copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to

collect any applicable copayments 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 copayment at the time service is provided unless exempted (see (2), (3) and (4) above).

(7) The provider should not deduct the copayment 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 copayment from the amount paid to the provider (whether or not provider collects the copayment from the client). If the OMAP paid amount is less than the required copayment, the copayment amount will be equal to what OMAP 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, OMAP does not require providers to bill or collect a copayment from the Medicaid recipient. The provider may choose not to bill or collect a copayment from a Medicaid recipient, however, the agency will still deduct the copayment amount from the Medicaid reimbursement made to the provider.

(9) OHP Standard copayments are eliminated for OHP Standard clients effective June 19, 2004. Elimination of copayments 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 OMAP program rule(s), that contain or refer to OHP Standard copayment requirements.

(10) Services which require copayments 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 copayment assessed per provider/per visit /per day unless otherwise specified. Copayment applies regardless of location, i.e. provider's office or client's residence;

(b) Mental Health Service copayments 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
Stat. Auth.: ORS 409
Stats. Implemented: 414.065

8-1-04

**Table 120-1230-1**

| OHP Benefit Package<br>Client Copayment Requirements | OHP Plus<br>Effective 1/1/03 | OHP Standard<br>Effective 8/1/04 |
|---|---|---|
| Acupuncture services | $3 | $0 |
| Ambulatory Surgical Center | $3 | $0 |
| Ambulance Service (emergency) | $0 | $0 |
| Audiology services<br>Hearing Aids | $3<br>$0 | $0<br>Not covered |
| Chemical Dependency Services<br><br>Outpatient services<br>Medication dosing/dispensing, case management<br>Inpatient hospital detoxification | <br><br>$3<br>$0<br><br>$0 | <br><br>$0<br>$0<br><br>$0 |
| Chiropractic services | $3 | Not covered |
| Dental Services –<br>Diagnostic<br>Restorative | <br>$0<br>$3 | <br>$0<br>$0 |
| DME and supplies | $0 | $0 |
| Hospital<br><br>Inpatient Care<br>Outpatient Surgery<br>Emergency Room Services<br>Outpatient other<br>Non-emergent visit performed in the ER | <br><br>$0<br>$3<br>$0<br>$3<br>$3 | <br><br>$0<br>$0<br>$0<br>$0<br>$0 |
| Laboratory Tests | $0 | $0 |
| Mental Health Services<br><br>Outpatient services<br>Medication dosing/dispensing, case management<br>Inpatient hospitalization<br>OP Hospital for ECT<br>ECT professional fee<br>Initial assmt/eval by psychiatrist<br>Consult between professionals | <br><br>$3<br>$0<br><br>$3<br>$3<br>$3<br>$3<br>$0 | <br><br>$0<br>$0<br><br>$0<br>$0<br>$0<br>$0<br>$0 |
| Naturopathic services | $3 | $0 |

| | | |
|---|---|---|
| Vision services<br><br>Exams- medical<br>Exams- for purpose of glasses<br>Frames, contacts corrective devices | <br><br>$3<br>$3<br>$0 | <br><br>$0<br>Not covered<br>Not covered |
| Prescription Drugs<br><br>Generic<br>Brand<br><br>*STC 7&11 Drugs: All MCO enrollees are subject to the same copays for these drugs. | <br><br>$2<br>$3 | <br><br>$0<br>$0 |
| Professional Visits for:<br><br>Primary care, including urgent care: i.e. Physician, Physician Assistant or Nurse Practitioner<br><br>Specialty Care<br>Office Medical Procedure<br>Surgical Procedure<br>PT/OT/Speech<br><br>Home Visits For:<br>Home Health<br>Private Duty Nursing<br>Enteral/Parenteral | <br><br>$3<br><br><br>$3<br>$0<br>$0<br>$3<br><br><br>$3<br>$3<br>$3 | <br><br>$0<br><br><br>$0<br>$0<br>$0<br>Not covered<br><br><br>Not covered<br>Not covered<br>0 |
| Podiatry services | $3 | $0 |
| Radiology<br>Diagnostic Procedures<br>Treatments | <br>$0<br>$0 | <br>$0<br>$0 |

* FQHC/RHC copays- refer to 410-127-0085 for details.
* Dental Services copays- refer to OAR 410-123-1085.

8-1-04

**410-120-1260 Provider Enrollment**

(1) This rule applies only to providers seeking reimbursement from OMAP, except as otherwise provided in OAR 410-120-1295.

(2) Signing the provider application constitutes agreement by performing and billing providers to comply with all applicable rules of the Medical Assistance Program and federal and state laws and regulations.

(3) A performing provider is the provider of a service or item. A billing provider is a person or business entity who/that submits claims on behalf of a performing provider. All references to "provider" in this and other rules of the Medical Assistance Program include both performing and billing providers.

(4) An individual or organization must meet applicable licensing and/or regulatory requirements set forth by Federal and State statutes, regulations, and rules to be enrolled and to bill as a provider. In addition, all 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.

(5) An individual or organization that is currently subject to sanction(s) by the Medical Assistance Program or Federal government is not eligible for enrollment (see Provider Sanctions).

(6) A 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 documents;

(b) The signing of the provider application by the provider or a person authorized by the provider to 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 by OMAP or the Division responsible for enrolling the provider.

(7) Performing providers may be enrolled retroactive to the date services were provided to a Medical Assistance client if:

(a) The provider was appropriately licensed, certified and/or otherwise met all Medical Assistance Program requirements for providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date of application for Medical Assistance provider status.

(8) Issuance of a provider number establishes enrollment of an individual or organization as a provider for limited category (ies) of services for the Medical Assistance Program.

(9) If a provider changes address, business affiliation, licensure, ownership, certification, billing agents or Federal Tax Identification Number (TIN), the Office of Medical Assistance Programs must be notified in writing within 30 days of the change. Failure to notify OMAP of a change of Federal Tax Identification Number may result in the imposing of a $50 fine. Changes in business affiliation, ownership, and Federal Tax Identification Number may require the submission of a new application. Payments made to providers who have not furnished such notification may be recovered.

(10) Providers of services outside the state of Oregon will be enrolled under the following conditions:

(a) The provider is appropriately licensed and/or certified and meets standards established within the provider's state for participation in the state's Medicaid program. Disenrollment from the other state's Medicaid program is a basis for disenrollment in the Oregon Medical Assistance Program;

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

(c) For noncontiguous out-of-state providers, the services provided must be for a specific Oregon Medicaid client who is temporarily outside Oregon or

the contiguous area of Oregon, or for foster care or subsidized adoption children placed out of state, or the provider is seeking Medicare deductible or coinsurance coverage for QMB clients;

(d) The services for which the provider bills are covered services under the Oregon Medical Assistance Program;

(e) 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;

(f) Out-of-state providers may provide contracted services per OAR 410-120-1880.

(11) Enrollment of Billing Providers:

(a) A person or business entity who/that submits claims to the Medical Assistance Program and/or receives payments from the Medical Assistance Program on the behalf of a professional provider (e.g., physician, physical therapist, speech therapist). The person/business entity must be enrolled with OMAP and meet all applicable federal regulations;

(b) A billing provider number will be issued only to billing providers billing on behalf of providers who have signed the provider enrollment form, who have met the licensure or other standards for enrollment as a provider and who have been delegated the authority to act on behalf of an the performing provider and to bill on behalf of the provider of service;

(c) A billing provider must maintain, and make available to the Medical Assistance Program, upon request, records indicating the billing provider's relationship with the provider of service;

(d) 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. This authorization must be maintained in the Billing Provider's files for at least five years, following the submission of claims to OMAP.

(12) Enrollment 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/she is absent for reasons such as illness, vacation, continuing medical education, pregnancy, etc.

(b) Locum tenens are not required to enroll with OMAP. The absentee physician must bill with their individual Medicaid 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.

(13) 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;

(b) Providers with reciprocal billing arrangements are not required to enroll with OMAP. The absentee physician must bill with their individual Medicaid 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;

(c) 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.

(14) Provider termination:

(a) The provider may terminate enrollment at any time. The request must be in writing, via certified mail, return receipt requested. The notice shall specify the 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) OMAP 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 the Department of Human Services, 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.

(15) When one or more of the requirements governing a provider's participation in the Medical Assistance program are no longer met, the provider's Medical Assistance Program 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 Medical Assistance Program number will be revoked.

(16) The provision of health care services or items to clients of the Medical Assistance Program is a voluntary action on the part of the provider. Providers are not required to accept all Medical Assistance clients seeking service.

(17) In the event of bankruptcy proceedings, the provider must immediately notify the Director of OMAP in writing.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

**410-120-1280 Billing**

(1) Medicaid Covered Services: The provider must not bill the Medical Assistance Program more than the provider's Usual Charge (see definitions).

(a) A provider enrolled with the Office of Medical Assistance Programs or a Managed Care Plan under the Oregon Health Plan must not seek payment from a client eligible for Medical Assistance benefit, or from a financially responsible relative or representative of that individual, for any services covered by Medicaid fee-for-service or through contracted managed care plans, including any coinsurance, co-pays, and deductibles.

(b) Except under the circumstances described below:

(A) The client did not inform the provider of Medical Assistance Program eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage, either at the time the service was provided or subsequent to the provision of the service or item, and as a result the provider could not bill the Medical Assistance Program, 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;

(B) The client became eligible for Medical Assistance benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate provider rules (i.e., retroactive authorization);

(C) A third party resource made payments directly to the client for services provided;

(D) The client did not have full Medical Assistance benefits. Clients

receiving a limited Medicaid coverage such as the Citizen Alien Waived Emergency Medical Program, MEDS or the Standard benefit package may be billed for services that are not benefits of those programs. The provider must document that the client was informed that the service or item would not be covered by the medical assistance program;

(E) 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;

(F) A client cannot be billed for services/treatment that has been denied due to provider error (i.e. required documentation not submitted, prior authorization not obtained, etc.);

(G) The charge is for a copayment when a client is required to make a copayment as outlined in OMAP General Rules (410-120-1230, 1235) and individual provider rules;

(H) In exceptional circumstances, a client may request to be able to receive 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 OMAP or the client's managed care plan, if the client is a member of a managed care plan;

(ii) The estimated cost of the covered service, including all related charges, the amount that OMAP or the client's managed care plan would pay for the service, and that the client cannot be billed for an amount greater than the maximum OMAP reimbursable rate or managed care plan rate, if the client is a member of a managed care plan;

(iii) That the provider cannot require the client to enter into a voluntary

payment agreement for any amount for the covered service;

(iv) And that, if the client knowingly and voluntarily agrees to pay for the covered service, the provider will not be able to submit a claim for payment to OMAP or the client's managed care plan;

(v) 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 shall be given a copy of the signed agreement.

A provider may not submit a claim for payment for covered services to OMAP or to the client's managed care plan that are subject to such agreement.

(2) Non-Covered Medicaid Services:

(a) A client may be billed for services that are not covered by the Medical Assistance Program or 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.

(c) A client can not 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 OMAP.

(3) All claims must be billed on the appropriate form as described in the individual provider rules.

(4) Upon submission of a claim to OMAP for payment, the provider agrees that it has complied with all rules of the Medical Assistance Program.

Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement.

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

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

(7) A claim may not be submitted prior to delivery of service. A claim may not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in OMAP's individual provider rules.

(8) 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 guide for specific instructions and requirements. Also, see "Valid Claim" in the Definitions section of these rules.

(9) Diagnosis Code Requirement:

(a) A primary diagnosis code is required on all claims, unless specifically excluded in an individual OMAP medical assistance programs' provider guide;

(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.

(10) For claims requiring a procedure code the provider must bill as

instructed in the appropriate Medical Assistance provider guide and must use the appropriate CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, which best describes the specific service or item provided. For claims which require the listing of a diagnosis and/or procedure code as a condition of payment, the code listed on the claim form must be the code which 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 guide Hospitals must follow national coding guidelines:

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

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

(11) No person shall submit or cause to be submitted to the Medical

Assistance Program:

(a) Any false claim for payment;

(b) Any claim altered in such a way as to result in a payment for a service which 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) which have not been provided.

(12) The provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Medical Assistance Program.

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

(14) Third Party Resources:

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Office of Medical Assistance Program 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 EEVS available to the provider;

(C) Verifying the client’s insurance coverage through AIS or the Medical Care Identification card on each date of service and at the time of billing.

(c) Except as noted in (14)(d)(A through E), when third party coverage is known to the provider, as indicated on the Medical Care Identification or through AIS, or any other means available, prior to billing the Medical Assistance Program:

(A) The provider must bill the third party resource; and

(B) Except for pharmacy claims billed through OMAP’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;

(C) Complied with the insurer’s billing and authorization requirements;

(D) Appealing 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 third party resource prior to billing the Medical Assistance Program, except under the following circumstances:

(A) Intermediate Care Facility Services for the mentally retarded;

(B) Institutional services for the mentally and emotionally disturbed;

(C) Prenatal and preventive pediatric services;

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

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer or liable party or place a lien against a settlement or the provider may bill the Medical Assistance Program. The provider may not both place a lien against a settlement and bill the Medical Assistance Program. The provider may withdraw the lien and bill the Medical Assistance Program within 12 months of the date of service. If the provider bills the Medical Assistance Program, the provider must accept payment made by the Medical Assistance Program as payment in full. The provider must not return the payment made by the Medical Assistance Program 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 (14)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing OMAP. Otherwise, OMAP will process the claim and if applicable will pay the OMAP allowable for these services and seek reimbursement from the liable third party insurance plan.

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

(e) The provider may bill the Medical Assistance Program 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. See the individual provider rules for further information on services that must be billed to Medicare first:

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

(B) Except as described in (14), any provider who accepts third party payment for furnishing a service or item to a Medical Assistance client shall:

(i) Submit an Individual Adjustment Request per instructions in the individual provider guide, indicating the amount of the third party payment; or

(ii) When the provider has already accepted payment from OMAP for the specific service or item, the provider shall make direct payment of the amount of the third party payment to the Medical Assistance Program. When the provider chooses to directly repay the amount of the third party payment to the Medical Assistance program, 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 payment by the Medical Assistance Program.

(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;

(g) The Medical Assistance Program reserves the right to make a claim against any third party payer after making payment to the provider of service. The Medical Assistance Program may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, request the provider bill the third party and refund OMAP in accordance with subsection 14;

(h) For services rendered to a Medicare/Medicaid dual eligible client, The Medical Assistance Program 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.

(15) Full Use of Alternate Resources:

(a) The Medical Assistance Program 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 16 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 Program; or

(E) Through other reasonably available resources.

(16) 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 payors of last resort, and are not considered an alternate resource or third party resource;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize veterans facilities whenever possible. Generally Veterans benefits are for service related conditions and as such is not considered an alternate or third party resource.

Table 1280 -TPR Codes.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

**Table 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 Medical Assistance Program 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 Medical Assistance Program 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 informationof why no TPR payment was made)

October 1, 2003

**410-120-1290 Labor and Delivery Out of Managed Care Organizations Service Area**

Until October 1, 1999, payment of labor, delivery, and well baby services in the hospital occuring outside of a managed care plan's service area for their enrolled members, will be made by Office of Medical Assistance Programs (OMAP), under OMAP's rules and payment schedule.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-1999(Temp), f. & cert. ef. 2-12-99 thru 6-30-99; OMAP 24-1999, f. 6-4-99, cert. ef. 6-30-99

**410-120-1295 Non-Participating Provider**

(1) For purposes of this rule, a provider enrolled with the Office of Medical Assistance Programs (OMAP) that does not have a contract with an OMAP-contracted managed care plan is referred to as a non-participating provider.

(2) For covered services that are subject to reimbursement from the managed care plan, a nonparticipating provider, other than a hospital governed by (3)(b) below, must accept from the OMAP-contracted managed care plan, as payment in full, the amount that the provider would be paid from OMAP if the client was fee-for-service.

(3) The OMAP-contracted 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) All other non-participating hospitals, not designated as a rural access or Type A and Type B hospital, for dates of service on or after October 1, 2003 reimbursement will be based upon the following:

(i) 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.

(ii) 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.

(4) The geographic factor, and the statewide average unit costs for inpatient service rates for subsection (3)(i) and for outpatient service rates for subsection (3)(ii), are calculated by the department's contracted actuarial firm. The inpatient and outpatient reimbursement table adopted

for the period October 1, 2003 to September 30, 2004 will be posted on the departments website at
http://www.dhs.state.or.us/policy/healthplan/guides/hospital/.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.743

3-23-2004 (T) 6-1-2004 (P)

**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 which was submitted within 12 months of the date of service, but which was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to OMAP. The provider must provide documentation acceptable to OMAP verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual provider guides. Acceptable documentation is:

(a) A remittance advice from OMAP which 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 OMAP.

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

(a) When the Office of Medical Assistance Programs or the client's branch office has made an error which caused the provider not to be able to bill within 12 months of the date of service. The error must be confirmed by the Medical Assistance Program;

(b) When a court or a Hearing Officer has ordered that the Medical Assistance Program make payment;

(c) When a client has been determined to be retroactively eligible for Medical Assistance Program 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
Hist.: PWC 683, f. 7-198-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 46-1980, f. & ef. 8-1-80; AFS 5-1981, f. 1-

23-81, ef. 3-1-81; Renumbered from 461-013-0080; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 17-1985, f. 3-27-85, ef. 5-1-85; AFS 55-1987, f. 10-29-87, ef. 11-1-87; HR 2-1990, f. 12-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0145; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0340; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98

**410-120-1320 Authorization of Payment**

(1) Some of the services or items covered by the Medical Assistance Program require authorization before payment will be made. Some services require authorization before the service can be provided. See the appropriate provider guide for information on services requiring authorization and the process to be followed to obtain authorization. Services (except medical transportation) for clients identified by OMAP as "medically fragile children", shall be authorized by 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 which contains all necessary documentation and meets any other requirements as described in the appropriate provider guide.

(3) The authorizing agency will authorize for the level of care or type of service which 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) Upon request by OMAP, 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/or 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 and/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 guide.

(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 where clients are made retroactively eligible, authorization for payment may be given if (A) through (C) of this rule are met;

(b) Services provided when a Title XIX client is retroactively disenrolled from a plan or services provided after the client was disenrolled from a plan may be authorized if (A) through (C) of this rule are met:

(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 OMAP 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) Period of Authorization: Authorization of payment is valid for the time period specified on the authorization notice, but not to exceed 12 months.

(8) Payment Authorization for Clients with Other Insurance or for Medicare Beneficiaries:

(a) Medicare: When Medicare is the primary payer for a service, no payment authorization from OMAP is required, unless specified in the appropriate program provider rules;

(b) Private Insurance or Other Third Party Resources: For clients who have other third party resources (Blue Cross, Champus, etc.), payment authorization is required as specified above and in the appropriate provider guide when the other insurer or resource does not cover the service and/or when the other insurer reimburses less than the OMAP rate;

(c) Managed Care Providers: Authorization for some services for clients in SHMOS (Medicare's Social Health Maintenance Organization) is required by the managed care provider. Services which are covered under the Medical Assistance Program but which are not covered under the SHMO's require authorization as specified above and in the appropriate provider guide.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

**410-120-1340 Payment**

(1) The Medical Assistance Program will make payment only to the enrolled provider who actually performs the service or the provider's enrolled billing provider for covered services rendered to eligible clients. Federal regulations prohibit OMAP from making payment to collection agencies. The Medical Assistance Program may require that payment for services be made only after review by the Medical Assistance Program.

(2) Fee-for-service payment rates are set by the Office of Medical Assistance Programs and/or the Division administering the program under which the billed services or items are provided.

(3) All fee-for-service payment rates will be the lesser of the amount billed, the Medical Assistance Program allowed amount or the reimbursement specified in the individual program provider rules.

(4) Inpatient hospital service will be reimbursed under the DRG methodology for inpatient hospital services, unless specified otherwise in the hospital services rules. Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by Federal regulation.

(5) All out-of-state hospital services are reimbursed at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 Division 125) unless the hospital provides highly specialized services and has a contract or service agreement with the Office of Medical Assistance Programs for those services.

(6) Payment rates for in-home services provided through SPD will not be greater than the current Medical Assistance rate for nursing facility payment.

(7) Payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities will be set by Department of Human Services staff at a rate:

(a) That is consistent with similar services provided in the State of Oregon; and (b) Is 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 Program in that state for that service; or

(c) Is the rate established by SPD for out-of-state nursing facilities.

(8) The Medical Assistance Program will not make payment on claims which have been assigned, sold, or otherwise transferred or on which the billing provider receives a percentage of the amount billed 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) The Medical Assistance Program will not make a separate payment or co-payment 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 and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services and Home Enteral/Parenteral Nutrition and IV Services provider rules, OAR 410 Division 148;

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program provider rules, OAR 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 provider rules, OAR 410 Division 122;

(d) Influenza immunization serum as described in the Pharmaceutical Services provider rules, OAR 410 Division 121;

(e) Podiatry services provided under the rules in the Medical-Surgical Services provider rules, OAR 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, OAR 410 Division 130;

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies provider rules, OAR 410 Division 122.

(10) The Medical Assistance Program 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 clients with Medicare:

(a) Payment from the Medical Assistance Program is limited to the Medicaid allowed amount less the Medicare payment up to the Medical Assistance Program allowable rate. The amount paid by the Medical Assistance Program cannot exceed the co-insurance and deductible amounts due;

(b) Payment from the Medical Assistance Program for services, which are covered Medical Assistance services but are not covered by Medicare is made at the Medical Assistance Program allowable rate.

(12) Payment for clients with other third-party resources. Payment is the Medical Assistance Program rate less the third party payment but not to exceed the billed amount.

(13) Payment in Full -- Medical Assistance Program payments, including contracted managed care plan payments, unless in error, constitute payment in full, except for limited instances involving allowable spendown or copayments. For the Medical Assistance Program this includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the Medical Assistance Program's 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.

Publications: Publications referenced are available from the agency.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

**410-120-1350 Buying-Up**

(1) Providers are not permitted to bill and accept payment from OMAP 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 patient;

(c) For example, an additional client payment to obtain a gold crown (not covered) instead of the stainless steel crown (covered); an additional client payment to obtain eyeglass frames not on the OMAP or plan contract. If a client wants to purchase a non-covered service or item, they must be responsible for full payment. OMAP or plan payment for a covered service cannot be credited toward the non-covered service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 10-1999, f. & cert. ef. 4-1-99

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

The Department of Human Services is responsible for analyzing and monitoring the operation of the Medical Assistance Program 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 and/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 which are adequately documented. Documentation must be completed before the service is billed to the Medical Assistance Program:

(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 guide 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 the Department of Human Services, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services, 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 the Department of Human Services, Medicaid Fraud Unit, or Department of Health and Human Services, 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 the Department of Health and Human Services; 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 the Department of Human Services 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 the Medical Assistance Program or to sanctions.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-04

**410-120-1380 Compliance with Federal and State Statutes**

(1) Compliance with Federal and State Statutes. Submission of a claim for medical services or supplies provided to a Medical Assistance client shall be deemed 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) Title II and Title III of the Americans with Disabilities Act of 1991;

(c) Title VI of the Civil Rights Act of 1964;

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

(2) Hospitals, nursing facilities, home health care 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 the Office of Medical Assistance Programs (OMAP) of the appropriate billing form requesting payment for medical services provided to a Medicaid eligible client shall be deemed representation to OMAP of the medical provider's compliance with the above-listed laws.

(3) Child Abuse Reporting. Providers described in ORS chapter 419B are required to report suspected child abuse to their local office of the State Office for Services to Children and Families 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.

[Publications: The publications referenced in this rule are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-13-160 & 461-13-180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0040 & 410-120-0400; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00

**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 shall 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 which 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 shall comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees shall 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) Advanced notice must be provided of meetings, location, and principal subjects to be discussed. Posting notices on the Website operated by the DHS Office of Medical Assistance Programs shall be sufficient compliance of the advanced notice requirement. Interested persons including news media may request hard copy notices by contacting the OMAP Communications Unit.

(c) Minutes must be taken at meetings and shall be made available to the public upon request to the contact person identified on the public notice.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2001, f. 12-28-01, cert. ef. 1-1-02

**410-120-1390 Sponsorships**

(1) Donations made for the benefit of one or more specified OMAP clients shall be referred to as a sponsorship and the donor shall be referred to as a sponsor.

(2) DHS may accept 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 sponsorship program. DHS does not operate or administer a sponsorship program. DHS does not find sponsors for clients or take requests or applications to be sponsored from clients.

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

(5) A sponsorship amount that is not actually received by the OMAP client shall not be deemed to be cash or other resource attributed to the OMAP client, except to the extent otherwise required by federal law. An OMAP client's own payment of his or her obligation, or payment made by an authorized representative of the OMAP client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (7) of this rule.

(6) Nothing in this rule alters the OMAP 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 rule of the Department of Human Services. If a sponsorship payment is accepted by DHS 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 sponsorship payment is made or that a sponsorship payment has stopped being made.

(7) 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 sponsorships that are not “bona fide donations” within the meaning of 42 CFR 433.54. A sponsorship is a “bona fide donation” if the sponsorship has no direct or indirect relationship to Medicaid payments made to the 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” shall have the same meaning as those terms are defined in 42 CFR 433.52. Sponsorships made by a health care provider or an entity related to a health care provider must be a “bona fide donation” within the meaning of subsection (a) of this section;

(c) 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 sponsorship to DHS (referred to as an organizational sponsor), the organizational sponsor is subject to this rule. The sponsorship must be a “bona fide donation” within the meaning of subsection (a) of this section;

(d) Any sponsor that is a health care provider or entity related to a health care provider, or causing another to make a 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

June 1, 2004 (T)

**410-120-1400 Provider Sanctions**

(1) There are two classes of provider sanctions, mandatory and discretionary, as outlined in OAR 410-120-1420, Basis for Mandatory Sanctions, and OAR 410-120-1440, Basis for Discretionary Sanctions.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0600

**410-120-1420 Basis for Mandatory Sanctions**

(1) Basis for Sanction:

(a) Medical Assistance Program Sanctions: Mandatory sanctions will be imposed when a provider of medical services has been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act and/or related state laws (or entered a plea of nolo contendere);

(b) Medical Assistance Program Sanctions based on Medicare Sanctions:

(A) Mandatory sanction will be imposed when a provider of medical services is excluded from participation in the Medicare program (Title XVIII) of the Social Security Act, as determined by the Secretary of Health and Human Services;

(B) The provider will be suspended from participation in the Oregon Medical Assistance Program while suspended from participation in the Medicare program.

[ED NOTE: The publications referenced to in this rule is available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0620; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

**410-120-1440 Basis for Discretionary Sanctions**

(1) Basis for Sanction: Sanction(s) may be imposed on a provider when one or more of the requirements governing provider participation in the Medical Assistance program are no longer met, as determined by the Medical Assistance Program.

(2) Conditions which may result in a 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/her health care license suspended or revoked, or has otherwise lost such license; or

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

(e) Been suspended or excluded from participation in a 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 patient'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 and/or contract with the Medical Assistance Program, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the patient;

(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 and/or to furnish as requested, records, or grant access to facilities upon request of the Medical Assistance Program or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;

(l) In the case of a hospital, failed to take corrective action as required by the Medical Assistance Program, based on information supplied by the Professional Review Organization, to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Medical Assistance Program;

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

(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 which 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 which 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 which document charges incurred by a client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records which 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, rule, or regulation;

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

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

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

(v) Rebated or accepted a fee or portion of a fee or charge for a Medical Assistance Program client referral; or collected a portion of a service fee

from the client, and billed the Medical Assistance Program for the same service;

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

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

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

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

(aa) Failed to properly account for a Medical Assistance Program 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 which resulted in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;

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

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

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

(3) A provider who has been 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 provider or other provider, for any services or supplies provided under the Medical Assistance Program, except those services or supplies provided prior to the date of suspension or termination.

(4) No provider shall submit claims for payment to the Medical Assistance Program for any services or supplies provided by a person or provider entity that has been 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 suspension or termination.

(5) When the provisions of subsections (3) or (4) are violated the Medical Assistance Program may suspend or terminate the billing provider and/or any individual performing provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0640; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00

**410-120-1460 Type, Duration, and Determination of Sanction**

(1) Mandatory sanctions:

(a) The provider will be either terminated or suspended from participation in Oregon's Medical Assistance Program (Medicaid and General Assistance);

(b) If suspended, the minimum duration of suspension will be determined by the Secretary of the Department of Health and Human Services, 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 Program longer than the minimum suspension determined by the Secretary of the Department of Health and Human Services.

(2) Discretionary sanctions. The following sanctions may be imposed on a provider by the agency:

(a) The provider may be terminated from participation in Oregon's Medical Assistance Program;

(b) The provider may be suspended from participation in Oregon's Medical Assistance Program for a specified length of time, and/or until specified conditions for reinstatement are met and approved by the state;

(c) The Medical Assistance Program may withhold payments to a provider;

(d) The provider may be required to attend provider education sessions. All costs shall be paid by the sanctioned provider;

(e) The Medical Assistance Program may require that payment for certain services be made only after documentation supporting the services has been reviewed by the Medical Assistance Program;

(f) The Medical Assistance Program may recover investigative and legal costs;

(g) The Medical Assistance Program 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 and/or compel future compliances with Federal, State and/or Agency regulations.

(3) The following factors shall be considered 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 peer review groups, licensing boards or a Peer Review Organization; and

(h) Adverse impact on the health of the Medical Assistance Program clients living in the provider's service area.

(4) When one or more of the requirements identified in this rule are no longer met, the provider's Medical Assistance Program 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 Medical Assistance Program number will be revoked. Immediate suspension of a provider will occur to prevent public harm or inappropriate expenditure of public funds. A decision to immediately suspend a provider will be made at the sole discretion of OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0050; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the

branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095 & 461-013-0140; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0260 & 410-120-0660; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00

## 410-120-1480 Notice of Immediate, Proposed and Final Sanctions

(1) If the Medical Assistance Program makes a decision to sanction a provider, the provider will be notified by certified mail or personal service of the intent to sanction. The provider may appeal this action within 30 days of the date of the notice. The provider must appeal this action separately from any appeal of audit findings and overpayments.

(2) The notice of immediate or proposed sanction shall identify:

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

(b) Explanation of actions expected of the provider;

(c) Explanation of subsequent actions the Medical Assistance Program intends to take;

(d) The provider's right to dispute the Medical Assistance Program's allegations, and submit evidence to support the provider's position; and

(e) The provider's right to appeal the Medical Assistance Program's proposed actions pursuant to OAR 410-120-1560, Provider Appeals through 410-120-1800, Provider Hearings -- Postponement.

(3) If the Office of Medical Assistance Programs makes a final decision to sanction a provider the Office of Medical Assistance Programs will notify the provider in writing at least 15 calendar days before the effective date of action.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0680; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

**410-120-1500 Additional Remedy and Other Provisions**

(1) The provider may appeal the Medical Assistant Program's proposed sanction(s), or other action the agency intends to take, including but not limited to termination or suspension from participation in the Medicaid funded Medical Assistance Program as well as the State funded portions of the program, pursuant to OAR 410-120-1580, Provider Appeals -- Administrative Review. A written notice of appeal must be received by the agency within 30 days of the date sanction notice was mailed to the provider.

(2) Other Provisions:

(a) When a provider has been sanctioned, all other provider entities in which the provider has ownership (5 percent or greater) or control of, may also be sanctioned;

(b) When a provider has been sanctioned, the Medical Assistance Program may notify the applicable professional society, board of registration or licensure, Federal or State agencies, OHP Managed Care Plans and the National Practitioner Data Base of the findings and the sanctions imposed;

(c) At the discretion of the Medical Assistance Program, providers who have previously been terminated or suspended may not be re-enrolled as providers of Medicaid services;

(d) Nothing in this rule shall prevent the agency from simultaneously seeking monetary recovery and imposing sanctions against the provider;

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 41-1991, f. & cert. ef. 10-

1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0700; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

**410-120-1520 Denial or Recovery of Reimbursement Resulting from Medical Review**

(1) The Department of Human Services' staff or medical review contractor or dental review contractor may review/audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the Medical Assistance Program's policy and rules and the generally accepted standards of a provider's field of practice or specialty.

(2) Payment may be denied or subject to recovery if medical review or audit determines the service was not provided in accordance with the Medical Assistance Program's policy and rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment. Related practitioner and hospital billings will also be denied or subject to recovery.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

4-1-04

**410-120-1540 Recovery of Overpayments to Providers resulting from medical review/audit**

(1) When the Department of Human Services determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery:

(a) To determine the overpayment amount, the Department of Human Services may use the 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., ("Calvin Paper"). The Department of Human Services hereby adopts by reference, but is not limited to, the method of random sampling described in the Calvin Paper;

(b) After the Department of Human Services determines an overpayment amount by the random sampling method set forth in subsection (a) of this rule, the provider may request a 100 percent audit of all billings submitted to the Medical Assistance Program for services provided during the period in question. 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 a certified public accountant who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and must be conducted within 120 calendar days of the request to use such audit in lieu of the Medical Assistance Program's random sample.

(2) The amount of medical review/audit overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Medical Assistance Program; 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.

(3) The Department of Human Services will deliver to the provider by registered or certified mail or in person a request for repayment of the overpayment and the documentation to support the alleged amount.

(4) If the provider disagrees with the Medical Assistance Program's determination and/or the amount of overpayment the provider may appeal the decision by requesting a contested case hearing or administrative review:

(a) A written request for hearing or administrative review of the decision being appealed must be submitted to the Medical Assistance Program by the provider pursuant to OAR 410-120-1660, Provider Appeal - Hearing Request. The request must specify the area(s) of disagreement;

(b) Failure to request a hearing or administrative review in a timely manner constitutes acceptance by the provider of the amount of the overpayment.

(5) The overpayment is due and payable 30 calendar days from the date of the decision by the Medical Assistance Program:

(a) An additional 30 day grace period may be granted the provider upon request to the Medical Assistance Program;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(6) The Department of Human Services may extend the reimbursement period or accept an offer of repayment terms. Any change in reimbursement period or terms must be made in writing by the Medical Assistance Program.

(7) If the provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Medical Assistance Program may:

(a) Recoup future provider payments up to the amount of the overpayment; and/or

(b) Pursue civil action to recover the overpayment.

(8) As the result of a hearing or review the amount of the overpayment may be reduced in part or in full.

(9) The Department of Human Services may, at any time, change the amount of the overpayment upon receipt of additional information. Any changes will be verified in writing by the Department of Human Services. Any monies paid to the Medical Assistance Program which exceed an overpayment will be refunded to the provider.

(10) If a provider is terminated or sanctioned for any reason the Department of Human Services may pursue civil action to recover any amounts due and payable to the Medical Assistance Program.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

4-1-04

**410-120-1560 Provider Appeals**

Effective for services provided on or after December 1, 2000. A provider may appeal certain decisions affecting the provider made by the Medical Assistance Program. There are three levels of appeal. Level 1 is a reconsideration on a claim(s). Level 2 is an administrative review and Level 3 is a contested case hearing; as outlined in OAR 410-120-1580, Provider Appeals - Administrative Review, through 410-120-1820, Provider Hearings - Hearing Attendance.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville,Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 0461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0780; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03

**410-120-1565 Provider Appeals -- Appeal of Payment/Sanction Decisions**

Providers may appeal:

(1) A denial of or limitation of payment allowed for services or items provided;

(2) A denial of provider's application for or continued participation in the Medical Assistance Program; or

(3) Sanctions imposed, or intended to be imposed, by the Medical Assistance Program on a provider or provider entity; and

(4) Overpayment determinations.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville,Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0840; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03, Renumbered from 410-120-1620

**410-120-1570 Provider Appeals (Level 1) - Claims Reconsideration**

A provider disputing OMAP's claim(s) decision may request

reconsideration. The provider must submit the request in writing to OMAP, Provider Services Unit within one year from OMAP's decision. The request must include the reason for the dispute, and any information pertinent to the outcome of the dispute. OMAP will complete an additional review and respond back to the provider in writing. If the provider is not satisfied with the review, the provider may request an Administrative Review or Contested Case Hearing as outlined in OAR 410-120-1580 through 410-120-1820.

Stat. Auth.: ORS 409

Stat. Implenented: 414.065

4-1-04

**410-120-1580 Provider Appeals (Level 2)-- Administrative Review**

(1) An administrative review allows an opportunity for the Director of the Medical Assistance Program or designee to reconsider a decision affecting the provider. The appeal may include the provision of new information or other actions that may result in the Medical Assistance Program, or prepaid health plan contractor, changing its decision. . The request for an administrative review:

(a) Must be in writing to the Director of OMAP;

(b) Must specify the issues or decisions being appealed and the reason for the appeal on each issue or decision. Give specifics for each claim such as procedure code, diagnosis code, reason for denial, administrative rule violated, and why the provider feels the outcome should be different. If all information is not included in the request, your request will be returned and you will need to resubmit;

(c) For clients enrolled in a managed care organization, the provider must exhaust all levels of the appeals process outlined by the enrollee's managed care organization prior to submitting an appeal to the Director (par and non-par providers). The MCO will be contacted to provide information in support of their decision. Provider must submit documentation that reflects completion of the review with the managed care plan;

(d) Must be filed and received by the Director of OMAP within 30 days of decision from OMAP or the final decision from the managed care plan.

(2) The Director of OMAP or designee will decide which decisions may be reviewed as administrative review or referred directly for a contested case hearing under this rule. If the Director denies a request for an administrative review, the provider may within thirty days of the denial make a written request for a contested case hearing subject to OAR 410-120-1565, Provider Appeals -- Appeal of Payment Decisions.

(3) If the Director decides that a meeting between the provider and Medical Assistance Program staff is required, the Director will:

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

(b) Notify the MCO (when client is enrolled in an MCO) of the date, time, and place the meeting is scheduled. The MCO 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 Director of the Office of Medical Assistance Programs, 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 and will be given ample opportunity to present relevant information;

(d) Medical Assistance Program staff will not be available for cross examination;

(e) Failure to appear constitutes acceptance of OMAP determination;

(f) The Director of OMAP or designee may request the 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 all providers involved in the review, in writing, within 30 days of the Administrative Review decision.

(6) All administrative review decisions are subject to judicial review under ORS 183.484 in the Circuit Court.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
October 1, 2003

**410-120-1600 Provider Appeals (Level 3) - Contested Case Hearings**

Effective for services provided on or after December 1, 2000.

(1) OAR 410-120-1640, Appeal of Payment Decisions, to OAR 410-120-1820, Provider Hearings - Hearing Attendance, are the procedural rules applying to contested case hearings conducted by the Medical Assistance Program.

(2) 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 409.010
October 1, 2003

**410-120-1640 Provider Appeals - Contested Case Hearing Definitions**

Effective for services provided on or after December 1, 2000. For purposes of hearings held under OAR 410-120-1600, Provider Appeals - Contested Case hearings - to 410-120-1820, Provider Hearings - Hearings Attendance, the following terms have these meanings:

(1) "Provider": A person or business entity who/which has requested a hearing. The term provider may also refer to the provider's representative where appropriate.

(2) "Medical Assistance Program": refers to the Division or Office within the Department of Human Services whose administrative action is being contested.

(3) "Medical Assistance representative": The Assistant Attorney General who represents the Medical Assistance Program, or a person designated by the Medical Assistance Program to act as a representative at the hearing, pursuant to OAR 410-120-1875.

(4) "Party": The provider or the prepaid health plan provider, or the Medical Assistance program (even though the Medical Assistance Program is not legally a party in these proceedings).

(5) "Prepaid Health Plan Provider": A Managed Care Plan that contracts with the Medical Assistance Program to provide services to clients, whose action is being contested.

(6) "Request for a hearing": A clear, written expression from the provider expressing disagreement with a decision by the Medical Assistance Program. The provider must specify the issues or decisions being appealed and the reason for the appeal on each issue or decision.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville,Lebanon, Albany and Corvallis, ef. 6-30-82 for

remaining AFS branch offices; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0860; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03

**410-120-1660 Provider Appeals -- Contested Case Hearing Request**

(1) A request for a contested case hearing is considered filed when the written request is received by the Director of OMAP or by the person designated by the Director, within thirty (30) calendar days of the date of the decision affecting the provider.

(2) An untimely hearing request will be denied after consideration by the Hearing Officer, unless it was untimely due to circumstances beyond the control of the provider.

(3) A contested case hearing will be denied, by order, upon the determination by the Hearing Officer that the issue being protested is not subject to the hearing process.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 51-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0195; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0880; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03

**410-120-1680 Provider Appeals - Contested Case Pre-Hearing Conference**

(1) After a hearing is requested, the Medical Assistance Program shall notify the provider(s) of the time and place of a pre-hearing conference. The purposes of this conference are:

(a) To provide an opportunity for the parties to settle the matter;

(b) To make sure the parties understand the reason for the action which is the subject of the hearing request;

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

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

(e) To determine if the parties wish to have any witness subpoenas issued.

(2) The provider(s) shall participate in the pre-hearing conference or provide to the Medical Assistance Program a statement of the issues being contested, including a detailed statement of the basis for the provider's disagreement.

(3) The Medical Assistance Program may grant to the provider the relief sought at any time.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 51-1985, f. 8-16-85; HR 2-1990, f.2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0205; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-012-0900; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03

**410-120-1685 Recovery of Overpayments to Providers - Recoupments and Refunds**

(1) The department may determine, as a result of review or other information, that an overpayment has been made to a provider, which indicates that a provider may have submitted bills and/or received payment to which he or she is not properly entitled. Such requests for refunds and recoupments may be based on, but not limited to, the following grounds:

(a) The department paid the provider an amount in excess of the amount authorized under the state plan or other policy of the department;

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

(c) The department paid the provider for services, items, or drugs that the provider did not perform or provide;

(d) The department paid for claims submitted by a data processing agent for whom a written provider/billing agent agreement was not on file at the time of submission;

(e) The department paid for services and later determined they were not part of the client's benefit package;

(f) Data processing submission/entry errors.

(2) When an overpayment is identified, the provider will be notified, in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the overpayment, and any further action which the department may take in the matter;

(3) The department may recover overpayments made to a provider by direct reimbursement, offset, civil action, or other actions authorized by law:

(a) Direct Reimbursement. Unless other regulations apply, the provider must reimburse the Department within thirty (30) calendar days from the date of the notice of the overpayment;

(b) Offset. The Department 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 (3)(b);

(c) Civil Action. The department may file a civil action in the appropriate Court and exercise all other civil remedies available to the Department in order to recover the amount of an overpayment;

(4) When the provider determines that an overpayment has been made, the provider shall notify and reimburse the department immediately, following one of the reimbursement procedures described below:

(a) Submitting a Medicaid adjustment form (OMAP 1036-Individual Adjustment Request). It is not necessary to refund with a check;

(b) Providers preferring to make a refund by check, attach a copy of the remittance statement page indicating the overpayment information. If the overpayment involves an insurance payment or another third party resource, attach a copy of the remittance statement from the insurance.

(A) Refund checks not involving third-party resouce payments should be made payable to OMAP Receipting - Checks in Salem.

(B) Refunds involving third-party resouce payments should be made payable and submitted to OMAP Receipting - MPR Checks in Salem.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.010
Hist.: OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03

**410-120-1700 Provider Appeals -- Proposed and Final Orders**

The hearing officer will conduct the hearing using the Attorney General's Model Rules at OAR 137-003-0501 and following:

(1) In a contested case hearing, the hearing officer shall serve a proposed order on the claimant and OMAP, unless prior to the hearing, OMAP notifies the hearing officer that a final order may be served. The proposed order will become a final order if no exceptions are filed within the time specified in subsection (2), unless OMAP notifies the parties and the hearing officer that OMAP will issue the final order.

(2) If the hearings officer issues a proposed order, and the proposed order is adverse to the provider, the provider may file exceptions to the proposed order to be considered by OMAP. The exceptions must be in writing and reach OMAP not later than 10 days after service of the proposed order. Additional evidence may be submitted only upon prior approval of OMAP. After receiving the exceptions, if any, OMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, OMAP may issue an amended proposed order.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0920; OMAP 41-2000, f. & cert. ef. 12-1-00

## 410-120-1720 Provider Appeals -- Hearing Evidence

Effective for services provided on or after December 1, 2000. The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Per 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. The provider must submit a claim for payment that is true and accurate and otherwise meets rule requirements. Therefore, the burden of proof is on the provider to establish that a claim for payment meets all Medical Assistance Program requirements, including documentation requirements.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 51-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0210 & 461-013-0215; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0940; OMAP 41-2000, f. & cert. ef. 12-1-00

**410-120-1820 Provider Hearings -- Hearing Attendance**

Effective for services provided on or after December 1, 2000. Hearings will be held in Salem, unless otherwise stipulated to by all parties.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-1040; OMAP 41-2000, f. & cert. ef. 12-1-00

**410-120-1860 Client Appeals**

(1) These rules apply to all contested case hearings of the Medical Assistance Programs involving a claimant'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. The method described in OAR 137-003-0520(8) is used in computing any period of time prescribed in this division of rules.

(2) Medical provider appeals and administrative reviews involving the Medical Assistance Program is governed by OAR 410-120-1580 through 410-120 1820.

(3) Hearing Requests:

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

(A) OMAP acts to deny services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in FCHP, DCO or CDO; or

(B) The right to a hearing is otherwise provided by statute or rule.

(b) A request for a hearing is complete when the Division's Administrative Hearing request form (AFS 443) is received by OMAP or by the Hearing Officer Panel of the Employment Division not later than the 45th day following the date of the decision notice.

(c) Delay in filing a hearing request caused by circumstances beyond the control of the claimant is not counted.

(4) 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 AFS Form 443.

(c) OMAP's Medical Directors Office staff will request all relevant medical documentation and present to OMAP's Medical Director for review. OMAP's Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the documentation applicable to the request, if the claimant is entitled to an expedited hearing.

(d) An expedited hearing will be allowed, if claimant has a medical condition which is determined, in a medical review by OMAP's Medical Director, to be an immediate, serious threat to claimant's life or health and claimant has been denied a medical service.

(5) Informal Conference:

(a) The Division representative and the claimant may have an informal conference, without the presence of the hearing officer, 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 OMAP and the claimant to settle the matter;

(B) Ensure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant 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 OMAP the chance to correct any misunderstanding of the facts;

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

(G) Give OMAP an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional conference with the Division Representative, which may be

granted in the discretion of the Division Representative if it will facilitate the hearing.

(c) OMAP may provide to the claimant the relief sought at any time before the Final Order is served.

(d) Notwithstanding any rule in this chapter of rules, prehearing conferences are governed by OAR 137-003-0575.

(6) Withdrawals: A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by OMAP or the hearing officer. The Hearing Officer 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 work day following the date such an order is served.

(7) Proposed and Final Orders:

(a) In a contested case, the hearing officer shall serve a proposed order on the claimant and OMAP, unless, prior to the hearing, OMAP notifies the Hearing Officer that a final order may be served. The proposed order will become a final order if no exceptions are filed within the time specified in subsection (b) unless OMAP notifies the parties and the hearing officer that OMAP will issue the final order.

(b) If the hearings officer issues a proposed order, and the proposed order is adverse to the claimant, the claimant may file exceptions to the proposed order or present argument to be considered by OMAP. The exceptions must in writing and reach OMAP not later than 10 working days after service of the proposed order. Additional evidence may be submitted only upon prior approval of OMAP. After receiving the exceptions, if any, OMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Division may issue an amended proposed order.

[ED. NOTE: Copies of the Form(s) referenced in this rule are available from the agency.]

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

Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0053; HR 19-1990, f. & cert. ef. 7-9-90; HR 35-1990(Temp), f. & cert. ef. 10-15-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1990, f. & cert. ef. 11-26-90; HR 11-1991(Temp), f. & cert. ef. 3-1-91; HR 34-1991, f. & cert. ef. 8-26-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00

**410-120-1865 Denial, Reduction, or Termination of Services**

(1) For written requests for services, all denials, reductions, or termination of services by the Division shall be in writing.

(2) When the Division authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate or reduce the course of treatment or a covered service, the Division 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.

(3) The Division shall have the following responsibilities in relation to subsection (2) of 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 Division 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 complaint; or

(C) The client is no longer eligible for Medical Assistance Program benefits.

(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 Division shall reinstate services if:

(A) The Division takes an action without providing the required notice and the client requests a hearing;

(B) The Division 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 Division 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 Division decides in the client's favor before the hearing.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 30-2000, f. 9-29-00, cert. ef. 10-1-00

**410-120-1870 Client Premium Payments**

All non-exempt clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120. Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
October 1, 2003

**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 agency in the following classes of hearings:

(a) Denial of Medical Assistance service coverage;

(b) Denial of prior authorization;

(2) Subject to the approval of the Attorney General, the DHS Audit Manager responsible for Medical Assistance Program audits is authorized to appear (but not make legal argument) on behalf of the agency in the following classes of hearings:

(a) Medical Assistance Program overpayment determinations;

(b) Medical Assistance Program provider sanction decisions.

(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 an agency officer or employee, or the DHS Audit Manager, represents the agency, the presiding officer shall 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 shall provide reasonable opportunity for the agency 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
October 1, 2003

**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), contracts may be implemented for covered services in any program area(s) of the Department of Human Services in order to achieve one or more of the following purposes:

(a) To implement and maintain prepaid health plan services.

(b) To ensure access to appropriate medical services which would otherwise not be available.

(c) To more fully specify the scope, quantity, and/or quality of the services to be provided and/or to specify requirements of the provider or to specify requirements of the Department of Human Services in relation to the provider.

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

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

(3) The Department of Human Services shall use the following screening and selection procedures when entering into contracts, interagency agreements and intergovernmental agreements under OAR 410-120-1880, subsection (1). Competition shall be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4).

(a) Informal Solicitation Procedure may be used for the procurement of services if the estimated cost or contract price is less than $75,000. Proposals shall be solicited from at least three sources, except as otherwise provided in these rules.

(b) Formal Solicitation Procedure shall be used for the procurement of services when the estimated cost or contract price is $75,000 or more. Proposals shall be solicited as outlined in these rules.

(4) Selection by Negotiation may be used for the procurement of goods or services if:

(a) Sole Source: 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/her expertise or situation. If the Director of the Department of Human Services, 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 shall be placed in the contract file.

(b) Emergency: Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the Director of the Department of Human Services, 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 shall be placed in the file.

(c) Federal Requirements: Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements shall be placed in the contract file.

(d) Agreements with state or other governmental entities are not subject to competitive solicitation.

(5) A Request for Proposal (RFP) or similar solicitation mechanism shall 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 RFP must be contested, and how and when the final award must be contested;

(i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by the Department of Human Services; and

(j) Contract provisions.

(6) Proposals shall 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 or rules adopted thereunder, the Department of Human Services shall obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 62-1986, f. 8-22-86, ef. 9-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0172; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0580; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2001, f. 3-30-01, cert. ef. 4-1-01

**410-120-1920 Institutional Reimbursement Changes**

(1) The Medical Assistance Program 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 DHS the state register is the Oregon Bulletin as 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.

ED NOTE: The publication(s) referenced in this rule are available from the agency.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 409.010
October 1, 2003

**410-120-1940 Interest Payments on Overdue Claims**

(1) Upon request by the provider, the Medical Assistance Program will pay interest on an overdue claim:

(a) A claim is considered "overdue" if not paid by the Medical Assistance Program 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 2/3 percent per month or eight percent per year.

(2) When billing the Medical Assistance Program 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 the Medical Assistance Program;

(f) Amount of billing on initial valid claim;

(g) Medical Assistance Program 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
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90;

Renumbered from 461-103-0185; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0360; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 42-2002, f. & cert. ef. 10-1-02

**410-120-1960 Payment of Private Insurance Premiums**

(1) Instead of paying providers directly, the Medical Assistance Program may pay insurance policy premiums or otherwise enter into agreements with other health insurance plans when it determines that payment of premiums and/or co-insurance and deductibles is likely to be cost effective, i.e., that the estimated net cost to the Medical Assistance Program will be less than the estimated cost of paying providers on a fee-for-service or other basis.

(2) The Medical Assistance Program will assure that all Medicaid covered services continue to be made available to eligible individuals for whom the Medical Assistance Program elects to purchase insurance.

(3) 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.

(4) Assessment of cost effectiveness will include:

(a) The past utilization experience of the client/eligible applicant as determined by past Medical Assistance and third party insurance utilization and claims data; and

(b) The current and probable future health status of the client/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.

(5) The Medical Assistance Program may purchase documents or records necessary to establish or maintain the client's eligibility for other insurance coverage.

(6) The Medical Assistance Program will not make payments for any benefits covered under the health insurance plan, except as follows:

(a) The Medical Assistance Program will calculate the Medical Assistance Program's allowable payment for a service. The amount paid by the other insurer will be deducted from the OMAP allowable. If the OMAP allowable exceeds the third party payment, OMAP will pay the provider of service the difference;

(b) The payment made by OMAP will not exceed any co-insurance, co-payment or deductible due;

(c) OMAP will make payment only for covered services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.115
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0170; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0500 & 410-120-0520

**410-120-1980 Requests for Information and Public Records**

(1) Non-exempt public records will be made available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) If copies of non-exempt public records are requested, a charge will be made to the requestor to cover actual costs. The charge must be paid before the requested copies are released. The charges will be based on the following:

(a) If the request for copies involves minimal staff time, the charge will be 20 cents a page;

(b) If the request is for ten pages or more and requires 15 minutes or more of staff time, the requestor will be charged for the actual cost of staff time taken to search, glean and edit the records, for computer costs if required, and for photocopying at 20 cents a page. The minimum hourly charge for staff time will be $8;

(c) When an Attorney General's review or consultation is required by OMAP, an additional charge will be made to cover the cost of that service.

(3) Part or all of the actual charges may be waived when the services provided will directly benefit OMAP or a client has need for copies of records and cannot afford the fee.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 192.410 - ORS 192.500
Hist.: HR 32-1993, f. & cert. ef. 11-1-93