DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Hospital Services

Rulebook

Includes:

1) Current Update Information (changes since last update)

2) Table of Contents

3) Complete set of Hospital Services Administrative Rules

Hospital Services Program Rulebook

Update Information

for

August 15, 2005

Effective: August 15, 2005

OMAP updated the Hospital Services Program Rulebook with the following temporary administrative rule revision:

OMAP temporarily amended 410-125-0141 to reflect an increase in the Unit Value component of the formula that reimburses hospitals for inpatient services paid on a Diagnosis Related Group (DRG) basis. This increase is needed to bring the reimbursement for DRG hospitals more in line with Medicare rates.

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

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 125

Hospital Services

410-125-0000 Determining When the Patient Has Medical Assistance

410-125-0020 Retroactive Eligibility

410-125-0030 Hospital Hold

410-125-0040 Title XIX/Title XXI Clients

410-125-0041 Non-Title XIX/XXI Clients

410-125-0045 Coverage and Limitations

410-125-0047 Limited Hospital Benefit Package for the OHP Standard Population

410-125-0050 Client Copayments

410-125-0080 Inpatient Services

Table 125-0080-1 Plus Benefit Package Prior Authorization List for Medical Services and Surgical Procedures

410-125-0085 Outpatient Services

410-125-0086 Prior Authorization for FCHP/MHO Clients

410-125-0090 Inpatient Rate Calculations -- Type A, Type B, and Critical Access Oregon Hospitals

410-125-0095 Hospitals Providing Specialized Inpatient Services

410-125-0100 OMPRO (Oregon Medical Professional Review Organization) Procedures

410-125-0101 Hospital-Based Nursing Facilities and Medicaid Swing Beds

410-125-0102 Medically Needy Clients

410-125-0103 Medicare Clients

410-125-0115 Non-Contiguous Area Out-of-State Hospitals

410-125-0120 Transportation To and From Medical Services

410-125-0121 Contiguous Area Out-of-State Hospitals

410-125-0124 Retroactive Authorization

410-125-0125 Free-Standing Inpatient Psychiatric Facilities (IMDS)

410-125-0140 Prior Authorization Does Not Guarantee Payment

410-125-0141 DRG Rate Methodology

410-125-0142 Graduate Medical Education Reimbursement for Public Teaching Hospitals -- Effective June 1, 1999

410-125-0145 Proportionate Share (Pro-Share) Payments for Public Academic Teaching Hospitals -- Inpatient

410-125-0150 Disproportionate Share (Effective for services rendered on or after January 1, 2001)

410-125-0155 Upper Limits on Payment (UPL) of Hospital Claims

410-125-0165 Transfers and Reimbursement

410-125-0170 Death Occurring on Day of Admission

410-125-0175 Hospitals Providing Specialized Outpatient Services

410-125-0180 Public Rates

410-125-0181 Non-Contiguous and Contiguous Area Out-of-State Hospitals - Outpatient Services

410-125-0190 Outpatient Rate Calculations -- Type A, Type B, and Critical Access Oregon Hospitals

410-125-0195 In State DRG Hospitals

410-125-0200 Time Limitation for Submission of Claims

410-125-0201 Independent ESRD Facilities

410-125-0210 Third Party Resources and Reimbursement -- Effective for Hospital Services Provided On or After July 1, 1991

410-125-0220 Services Billed on the UB-92 and Other Claim Forms

410-125-0221 Payment in Full

410-125-0360 Definitions and Billing Requirements

410-125-0400 Discharge

410-125-0401 Definitions: Emergent, Urgent, and Elective Admissions

410-125-0410 Readmission

410-125-0550 X-Ray or EKG Procedures Furnished in Emergency Room

410-125-0600 Non-Contiguous Out-of-State Hospital Services

410-125-0620 Special Reports and Exams and Medical Records

410-125-0640 Third Party Payers -- Other Resources, Client Responsibility and Liability

410-125-0641 Medicare

410-125-0720 Adjustment Requests

410-125-1020 Filing of Cost Statement

410-125-1040 Accounting and Record Keeping

410-125-1060 Fiscal Audits

410-125-1070 Type A and Type B Hospitals

410-125-1080 Documentation

410-125-2000 Access to Records

410-125-2020 Post Payment Review

410-125-2030 Recovery of Payments

410-125-2040 Provider Appeals -- Administrative Review

410-125-2060 Provider Appeals -- Hearing Request

410-125-2080 Administrative Errors

410-125-0000 Determining When the Patient Has Medical Assistance

(1) The Medical Card gives information about the client's eligibility and benefits.

(2) Eligibility may change on a monthly basis. In some instances, eligibility will change during the month. Request to see the Medical Card or contact Automated Information System (AIS) each time services are provided in order to assure that the client is eligible. Contact information can be found in the Hospital Services Supplemental Information and on the Office of Medical Assistance Programs (OMAPs) web site.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 409.010

10-1-04

410-125-0020 Retroactive Eligibility

(1) The Office of Medical Assistance Programs (OMAP) may pay for services provided to a person who does not have Medicaid coverage at the time services are provided if the person is made retroactively eligible for medical assistance and eligibility is extended back to the date services were provided. Contact the local branch concerning possible retroactive eligibility. In some cases, the date you contact the branch may be considered the date of application for eligibility.

(2) When clients are not eligible at the time services are provided, it is not possible to get prior authorization (PA) for service. However authorization for payment may be given after the service is provided under some circumstances. For additional PA information see OAR 410-125-0080 and 410-125-0047.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 409.010

10-1-04

410-125-0030 Hospital Hold

(1) A hospital hold is a process which allows an in-state general hospital or an out-of-state contiguous general hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization.

(2) The Office of Medical Assistance Programs (OMAP) will accept hospital holds for inpatient stays. Hospitals must either submit an OMAP 3261 or a hospital generated form to OMAP within 24 hours of the admission time or the next working day. If a hospital uses its own form, the form must contain all the information found on the OMAP 3261.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-04

410-125-0040 Title XIX/Title XXI Clients

(1) Title XIX /Title XXI clients are eligible for medical assistance through programs established by the Federal government and for which the State receives federal assistance. Most Title XIX/Title XXI clients are eligible for the Plus or Standard Benefit packages. See the General rules (Chapter 410 Division 120) for more information on eligibility, benefit package, and covered services. Most Title XIX/Title XXI clients are enrolled in a FCHP, a MHO and a DCO. Some Title XIX clients are Medicare Beneficiaries.

(2) The Office of Medical Assistance Programs (OMAP) contracts with Prepaid Health Plans (PHPs): Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), and Dental Care Organizations (DCOs), to provide certain medical, mental health and dental services on a prepaid basis.

(a) FCHPs provide a comprehensive package of health care benefits including hospital, physician, laboratory, X-ray and other diagnostic imaging, Medicheck (EPSDT), pharmacy, physical therapy, speech-language therapy, occupational therapy, case management, and other services.

(b) MHOs provide mental health services. They can be fully capitated health plans, community mental health programs, private behavioral organizations or a combination thereof.

(c) DCOs provide dental care.

(d) If the client is enrolled in a Prepaid Health Plan, the name, address and phone number of the plan will appear on the Medical Care Identification. Always check with the plan listed if there is a question about coverage.

(e) PHP clients receive most of their primary care services through the PHP or upon referral from the PHP. In emergency situations, all services may be provided without prior authorization or referral. However, all claims for emergency services must be sent to the prepaid health plan. The hospital must work with the client's prepaid health plan to arrange for billing and payment for emergency and non-emergency services.

(f) OMAP will not reimburse for services that can be provided by the client's PHP and are included in the PHP's contract as covered services. Reimbursement is between the service provider and the PHP.

(3) Medicare Clients: Some Title XIX clients also have Medicare coverage. Most Medicare beneficiaries who are also eligible for Medicaid will have the full range of covered benefits for both Medicare and Medicaid. However, a few individuals who are Medicare eligible are eligible for only partial coverage through Medicaid. Refer to the General rules (Chapter 410 Division 120) for information on eligibility.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
10-1-04

410-125-0041 Non-Title XIX/XXI Clients

(1) State-funded clients are clients who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of clients who are in State-funded programs.

(2) Program GA clients: Program GA clients are children in foster care, in SCF custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid covered services, but payment for services provided to these children may be different from that for Title XIX/Title XXI clients. For additional reimbursement information see the Hospital Services Supplemental Information on the Office of Medical Assistance Programs web site.

(3) Program SF clients: Program SF clients are individuals who are receiving treatment in a state facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. They sometimes need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred by the state facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The state will contact the hospital regarding billing instructions for these clients.

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

10-1-04

410-125-0045 Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the General rules for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require prior authorization. The Plus and Standard Benefit Packages may have different PA requirements. For the Plus Benefit Package check OAR 410-125-0080. Detailed PA information for the Standard Benefit Package is on the web site (http://www.dhs.state.or.us/healthplan/guides/hospital.

(2) Non-Covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Division are not covered by OMAP;

(b) Service coverage is based on the Health Services Commission's Prioritized List of Services and the benefit package;

(c) See the General rules (Chapter 410 Division 120) and other program divisions in Chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on Hospital Benefit Days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental Services: Clients have dental/denturist services identified as covered on the Health Services Commission Prioritized List (OAR 410-141-520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by OMAP as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services provided during a ground or air ambulance transport.

(6) Dialysis Services require a written physician prescription. The prescription must indicate the ICD-9 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules.

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

10-1-04

410-125-0047 Limited Hospital Benefit for the OHP Standard Population

(1) The Oregon Health Plan (OHP) Standard population has a limited hospital benefit for urgent or emergent inpatient and emergency room services effective on August 1, 2004 through August 31, 2004. The limited hospital benefit for inpatient, outpatient, and emergency room services is effective on and after September 1, 2004.

(2) The limited hospital benefit includes the ICD-9 CM codes listed in the OHP Standard Population – Limited Hospital Benefit Code List. This rule incorporates by reference the OHP Standard Population – Limited Hospital Benefit Code List. This list includes diagnoses requiring prior authorization indicated by letters prior authorization (PA) next to the code number. The most current list, dated September 1, 2004, is available on the web site (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact the Office of Medical Assistance Programs for hardcopy.

(3) The Office of Medical Assistance Programs (OMAP) will reimburse hospitals for inpatient (diagnostic and treatment) services, outpatient (diagnostic and treatment services) and emergency room (diagnostic and treatment) based on the following:

(a) For treatment, the diagnosis must be listed in the OHP Standard Population – Limited Hospital Benefit Code List;

(b) For treatment the diagnosis must be above the funding line on the Prioritized List of Health Services (HSC List) (OAR 410-141-0520);

(c) The diagnosis (ICD-9) must pair with the treatment (CPT code); and

(d) Prior authorization (PA) must be obtained for codes indicated in the OHP Standard Population – Limited Hospital Benefit Code List. PA request should be directed to OMAP's contracted Quality Improvement Organization (QIO) and will follow the present (current) PA process. PAs must be processed as expeditiously as the client's health condition requires.

(e) Medically appropriate services required to make a definitive diagnosis are a covered benefit.

(4) Some non-diagnostic outpatient hospital services (e.g. speech, physical or occupational therapy, etc.) are not a covered benefits for the OHP Standard population (see the individual program for coverage).

(5) For benefit implementation process and PA requirements for the client enrolled in a Fully Capitated Health Plan (FCHP) and/or Mental Health Organization (MHO), contact the client's FCHP or MHO. The FCHP and/or MHO may have different requirements than OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

11-01-04

410-125-0050 Client Copayments

Copayments may be required for certain services and/or benefit package(s). See OAR 410-120-1230 for specific details.

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

10-1-04

410-125-0080 Inpatient Services

(1) Elective (Not Urgent or Emergent) Admission:

(a) Fully Capitated Health Plan (FCHP) and Mental Health Organization (MHO) Clients -- contact the client's MHO or FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than Office of Medical Assistance Programs (OMAP);

(b) Medicare Clients OMAP does not require prior authorization for inpatient services provided to clients with Medicare Part A or B coverage;

(c) For OMAP clients covered by the OHP Plus Benefit Package:

(A) Hospital admissions for any of the medical and surgical procedures shown in Table 125-0080-1 require prior authorization, unless they are urgent or emergent;

(B) For prior authorization contact the OMAP contracted Quality Improvement Organization (QIO) unless otherwise indicated in Table125-0080-1.

(d) OMAP clients with OHP Standard Benefit Package have a limited hospital benefit package. Specific coverage and prior authorization requirements are listed in OMAP's Hospital Services Supplemental Information or at OMAP website (www.dhs.state.or.us/policy/healthplan/guides/hospital/) (referenced in OAR 410-125-0047).

(2) Transplant services:

(a) Complete rules for transplant services are in OMAP's Transplant Services rules (Chapter 410 Division 124);

(b) Clients are eligible for transplants covered by the Health Services Commission's Prioritized List of Health Services. See the Transplant Services rules for criteria. For clients enrolled in a FCHP, contact the plan

for authorization. Clients not enrolled in an FCHP, contact the OMAP Medical Director's office.

(3) Out-of-State non-contiguous hospitals:

(a) All non-emergent/non-urgent services provided by hospitals more than 75 miles from the Oregon border require prior authorization;

(b) Contact -- the OMAP Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP -- contact the plan.

(4) Out-of-statecontiguous hospitals: services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, are prior authorized following the same rules and procedures as instate providers .

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in Table 125-0080-1, e.g., inpatient physical rehabilitation care, require prior authorization – contact OMAP contracted QIO;

(b) Transfers to a skilled nursing facility, intermediate care facility or swing bed -- contact Seniors and People with Disabilities (SPD). SPD reimburses nursing facilities and swing beds through contracts with the facilities. For FCHP clients -- transfers require authorization and payment (for first 20 days) from the FCHP;

(c) Transfers to the same or lesser level of inpatient care -- OMAP will cover transfers, including back transfers, which are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social/psychological benefit to the patient. The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support. Transfers not meeting these guidelines may be denied on the basis of post-payment review;

(d) Exceptions:

(A) Emergency transfers do not require prior authorization;

(B) In state or contiguous non-emergency transfers for the purpose of providing care which is unavailable in the transferring hospital do not require prior authorization unless, the planned service is listed in Table 125-0080-1 of this rule;

(C) All non-urgent transfers to out-of-state non-contiguous hospitals require prior authorization.

(6) Dental procedures provided in a hospital setting:

(a) OMAP will reimburse for hospital services when covered dental services are provided in a hospital setting for clients not enrolled in a FCHP, when a hospital setting is medically appropriate. For prior authorization, contact the OMAP Dental Services Program coordinator;

(b) For clients enrolled in a FCHP, contact the client's FCHP;

(c) Emergency dental services do not require prior authorization.

Table 125-0080-1.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

Table 125-0080-1 Plus Benefit Package Prior Authorization List for Medical Services and Surgical Procedures

This table lists procedures that require prior authorization for the Plus Benefit Package. This table is provided as a convenience to providers, and is not a complete list of OMAP covered services requiring prior authorization.

For the most current information on services requiring prior authorization, refer to the appropriate program Division in Chapter 410. Unless otherwise indicated below contact OMAP's contracted Quality Improvement Organization for prior authorization.

Procedure	Code	Comments
Anesthesia	00580, 00796, 00938	If PA was not obtained for a procedure that requires PA, then anesthesia services may not be paid
Apnea Monitors, Services and Supplies (Outpatient)		PA through OMAP Medical Unit
Audiological Services (Outpatient)		Refer to Speech-Language Pathology, Audiology and Hearing Aid Services rules (Chapter 410 Division 129).
Biofeedback		
Bone Marrow	38230, 38240, 38241	PA through OMAP Medical Director's Office. See Transplant Servicesrules (Chapter 410 Division 124).
Cardiovascular	33935, 33945	PA through OMAP

		Medical Director's Office. See Transplant Servicesrules (Chapter 410 Division 124) .
Dental Services		Refer to Dental and Denturist Services rules (Chapter 410 Division 123).
Digestive System	40840, 40842-40845, 43631-43634, 47135*, 47136*, 47140*- 47142*, 48160*, 48554*, 48556*, 49000**, 49320, 49329	* PA through OMAP Medical Unit. See Transplant Services rules (Chapter 410 Division 123). ** PA required if elective
Drugs (Outpatient)		Refer to Durable Medical Equipment Services rules (Chapter 410 Division 122).
Eating Disorders (Inpatient Treatment)		ICD-9-CM Diagnosis: 307.1, 307.5
Female Genital System	51840, 51841, 51845, 56805, 57284, 57288, 57291, 57292, 57335, 58400, 58410, 58550, 58552-58554, 58660, 58661, 58672, 58673, 58720**, 58940	** PA required if elective
Hearing Aids (Outpatient)		Refer to Speech-Language Pathology, Audiology and Hearing Aid Services rules (Chapter 410 Division 122).
Home Health Services		Refer to Home Health Services rules (Chapter 410 Division 127).
Home Enteral/Parenteral Therapy		Refer to Home Enteral/Parenteral Nutrition and IV Services

		rules (Chapter 410 Division 148).
Hysterectomy	58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58550	
Inpatient Detoxification		ICD-9-CM Diagnosis: 291-292.9, 303-305.93
Integumentary System	11960, 11970, 15822, 15823, 17106*-17108*	* Coverage limited to facial lesions only
Male Genital System	54360, 54400-54401, 54405, 54408, 54410, 55411, 54416, 54417	
Musculosketal System	20910, 21050, 21137-21139, 21141, 21142, 21143, 21145-21147, 21150, 21151, 21154, 21155, 21159, 21160, 21172, 21175, 21179-21184, 21188, 21193-21196, 21198, 21199, 21206, 21208, 21209, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21280, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22841-22848, 22851, 23472, 26560-26562, 27447, 28340, 28341, 28344, 28345	
Nervous System	62351, 63001, 63003, 63005, 63011, 63012, 63015-63017, 63020, 63030, 63035, 63040,63042-63048,	

	63055-63057, 63064, 63066, 63075-63078, 63081, 63082, 63085-63088, 63090, 63091, 63101-63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194-63200, 63250-63252, 63265-63268, 63270-63273, 63275-63278, 63280-63283, 63285-63287, 63290, 63300-63308	
Occupational Therapy (Outpatient)		Refer to Physical and Occupational Therapy Rulebook.
Ophthalmology Services	65125, 65130, 65135, 65140, 65150, 65155, 67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, 67340*, 67550, 67560, 67900-67904, 67906, 67908, 67909, 67911, 67914-67917	
Otorhinolaryngology	92507	
Physical Rehabilitation		ICD-9-CM Diagnosis: V52.8, V52.9, V57.1-V57.3, V57.89, V57.9
Physical Therapy (Outpatient)		Refer to Physical and Occupational Therapy Services rules (Chapter 410 Division 131).
Private Duty Nursing		Refer to Private Duty

		Nursing Services rules (Chapter 410 Division 132).
Radiology	78459, 78491, 78492, 78608, 78609, 78810	
Respiratory Procedures	30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 32851*-32854*	* PA through OMAP Medical Director's Office. See Transplant Services rules (Chapter 410 Division 123).
Speech Therapy (Outpatient)		Refer to Speech-Language Pathology, Audiology, and Hearing Aid Services rules (Chapter 410 Division 129).

8-1-04

410-125-0085 Outpatient Services

(1) Outpatient services that may require prior authorization include (see the individual Program rules):

(a) Physical Therapy (Chapter 410 Division 131);

(b) Occupational Therapy (Chapter 410 Division 131);

(c) Speech Therapy (Chapter 410 Division 129);

(d) Audiology (Chapter 410 Division 129);

(e) Hearing Aids (Chapter 410 Division 129);

(f) Dental Procedures (Chapter 410 Division 123);

(g) Drugs (Chapter 410 Division 121);

(h) Apnea monitors, services, and supplies (Chapter 410 Division 131);

(i) Home Parenteral/Enteral Therapy (Chapter 410 Division 148);

(j) Durable Medical Equipment and Medical supplies (Chapter 410 Division 122);

(k) Certain hospital services.

(2) Outpatient Surgical procedures:

(a) FCHP Clients: Contact the client's FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than OMAP. Some services are not covered under FCHP contracts and require prior authorization from OMAP’s contracted Quality Improvement Organization (QIO), or the OMAP Dental Program coordinator.

(b) Medicare Clients enrolled in FCHPs: These services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider will not be paid beyond any Medicare payments (see also OAR 410-125-0103).

(c) For the Plus benefit package OMAP clients:

(A) Surgical procedures listed in OAR 410-125-0080 require prior authorization when performed in an outpatient or day surgery setting, unless they are urgent or emergent.

(B) Contact OMAP contracted QIO (unless indicated otherwise in OAR 410-125-0080).

(d) For the Standard benefit package OMAP client's outpatient surgical procedures: see OAR 410-125-0047 and the OHP Standard Population - Limited Hospital Benefit Package Code List (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact OMAP for a hardcopy, for coverage and prior authorization requirements.

(c) Out-of-State Services -- Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require prior authorization unless specified in these rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require prior authorization. For clients enrolled in an FCHP, contact the plan for authorization. For clients not enrolled in a prepaid health plan, contact the OMAP Medical Director's office.

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

10-1-04

410-125-0086 Prior Authorization for FCHP/MHO Clients

Most non-emergent inpatient and outpatient services require prior authorization by a Fully Capitated Health Plan (FCHP) or a Mental Health Organization (MHO). Emergency hospital services must be covered by an FCHP or MHO without regard to prior authorization or the emergency care provider's contractual relationship with the FCHP or MHO. Emergency hospital services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. Once a client's condition is considered stabilized, or a medical screening examination has determined that the client's medical condition is not emergent, an FCHP or MHO may require prior authorization for hospital admission, follow-up care, or further treatment. Failure to obtain prior authorization from the FCHP or MHO may result in a denial of payment for services. Contact the client's FCHP or MHO for further information on prior authorization.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
4-1-01

410-125-0090 Inpatient Rate Calculations -- Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except Laboratory and Radiology services are based on the Office of Medical Assistance Programs (OMAP) fee schedule.

(b) Retrospective cost-based reimbursement is made during the annual cost settlement period for all covered inpatient services, except for the hospitals that have payment contracts with managed care plans.

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

(3) Type A, Type B, and Critical Access Hospitals are eligible for disproportionate share reimbursements, but must meet the same criteria as other hospitals. See OAR 410-125-0150 for eligibility criteria and reimbursement calculation.

(4) Type A, Type B, and Critical Access Hospitals do not receive cost outlier, capital, or medical education payments.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

410-125-0095 Hospitals Providing Specialized Inpatient Services

(1) Some hospitals provide specific highly specialized inpatient services by arrangement with OMAP.

(2) Reimbursement is made according to the terms of a contract between OMAP and the hospital.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
11-18-91

410-125-0100 Quality Improvement Organization (QIO) Procedures

(1) The Office of Medical Assistance Programs (OMAP) contracts with a Quality Improvement Organization (QIO) to provide prior authorization for selected services. The contracted QIO approves or denies a request for non-emergency inpatient services based on recommendations from the QIO's physician review findings. Requests to the QIO for non-emergency inpatient hospital admissions may be submitted in writing (mail, fax) or by phone.

(2) The QIO has three working days to respond to a completed request for prior authorization. A completed request must contain all the information necessary for the QIO staff to recommend approval, denial, or to require a second opinion.

(3) Criteria used by the QIO to screen requests are: the QIO developed surgical criteria, InterQual Adult and Pediatric Medical criteria, the QIO Specialty Criteria for Psychiatric and Inpatient Rehabilitation Services, CMS Generic Quality Screens, and criteria for services developed by OMAP in conjunction with the QIO.

(4) The QIO staff can require a client seek a second opinion from a contracted second opinion physician if the appropriate criteria has not been met, or if the physician has not submitted adequate information. If the requesting physician disagrees with second opinion physician, the QIO can require a client have a third opinion. The requesting physician may ask the QIO to review the case after additional information is provided or may ask for a third opinion.

(5) If the second and third opinion physicians determine that the requested procedure or treatment is not likely to improve the basic health status of the client, or is not medically necessary, appropriate, or reasonable, OMAP will deny the request for prior authorization of payment based upon the recommendation of the QIO.

(6) The requesting physician may appeal a decision to deny reimbursement to OMAP.

(7) No payment will be made to the hospital or to the attending physician providing services for an inpatient hospital stay if the service is not authorized.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-0101 Hospital-Based Nursing Facilities and Medicaid Swing Beds

To receive reimbursement for hospital-based long-term care nursing facility services or Medicaid swing beds, the hospital must enter into an agreement with Seniors and People with Disabilities (SPD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with SPD rules. Contact SPD client's branch office for further information.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-0102 Medically Needy Clients

(1) The QIO can give prior authorization for non-emergency inpatient services for clients who are in the Medically Needy Program but have not yet met their spend-down. Only Medically Needy Program clients under age 21 and pregnant women have coverage for inpatient services if enrolled in the Medically Needy Program.

(2) Prior authorization cannot be granted for outpatient services, which require prior authorization. However, you may contact the OMAP Medical/ Dental Group once the client has been made eligible and request retroactive authorization.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065

10-1-04

410-125-0103 Medicare Clients

When Medicare is the primary payer, services provided in the inpatient or out patient setting do not require prior authorization. However, if OMAP is the primary payer because the service is not covered by Medicare; the prior authorization requirements listed in Chapter 410 Division 125 would apply.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065

10-1-04

410-125-0115 Non-Contiguous Area Out-of-State Hospitals

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for non-contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations from Other Hospitals, DRG Rate Methodology, OAR 410-125-0141 for the methodology used to calculate the unit value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
10-1-03

410-125-0120 Transportation To and From Medical Services

(1) Transportation to and from medical services, including hospital services, is a covered service. However, all non-emergency transports require prior authorization in order for the transportation provider to be paid.

(2) The transportation must be the least expensive obtainable under existing conditions and appropriate to the client's needs.

(3) Contact the client's branch office for prior authorization for the transport or instruct the transportation provider to contact the branch.

(4) No prior authorization is required when the client's condition requires emergency transport.

(5) When a hospital sends a patient to another facility or provider during the course of an inpatient stay and the client is returned to the admitting hospital within 24 hours, the hospital must arrange for and pay for the transportation. See billing instructions contained in the Hospital Supplemental Information on the OMAP's website for additional information.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-0121 Contiguous Area Out-of-State Hospitals

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
10-1-03

410-125-0124 Retroactive Authorization

Retroactive authorization for payment can be granted after the service is provided only in the following circumstances:

(1) The person was not yet eligible for Medicaid/CHIP at the time the services were provided. Payment can be made if the services are covered Medicaid/CHIP services and the client's eligibility is extended back to the date the hospital provided services. See: the Hospital Services Supplemental Information on the OMAP's website for additional billing information.

(2) If another insurer denied the claim because the service is not covered by that insurer, and the hospital did not seek prior authorization because it had good reason to believe the service was covered by the insurer. Payment can be made by OMAP if the services are covered by Medicaid. See: the Hospital Services Supplemental Information on the OMAP's website for additional billing information.

Stat. Auth.: ORS Ch 184
Stats. Implemented: ORS 414.065

10-1-04

410-125-0125 Free-Standing Inpatient Psychiatric Facilities (IMDS)

Free-standing inpatient psychiatric facilities (Institutions for Mental Diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Mental Health and Developmental Disability Services Division and the hospital.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
11-18-91

410-125-0140 Prior Authorization Does Not Guarantee Payment

(1) Prior authorization (PA) is valid for the date range approved only as long as the client remains eligible for services. For example, a client may become ineligible after the prior authorization has been granted but before the actual date of service, or a client's hospital benefit days may be used prior to the time the claim for the prior authorized service is submitted to the Office of Medical Assistance Programs (OMAP) for payment.

(2) All prior authorized treatment is subject to retrospective review. If the information provided to obtain prior authorization can not be validated in a retrospective review, payment will be denied or recovered.

(3) Hospitals should develop their own internal monitoring system to determine if the admitting physician has received prior authorization for the service from OMAP or OMAP's contracted Quality Improvement Organization (QIO).

(4) For the Plus Benefit Package PA information refer to the Prior Authorization Chart in the Hospital Services rules (OAR 410-125-0080-1).

(5) For the Standard Benefit Package PA information refer to the Standard Population – Limited Hospital Benefit Package Covered Code List at the website www.dhs.state.or.us/policy/healthplan/guides/hospital.

(6) Hospitals may also verify PA requirements by calling OMAP's Provider Services Unit or the RN Benefit Hotline (contact phone numbers are located on the OMAP website).

Stat. Auth.: ORS 184.750, ORS 409.010, ORS 409.110, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-0141 DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Office of Medical Assistance Programs (OMAP) uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. OMAP DRG weight tables can be found on the DHS web site.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, OMAP establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, OMAP uses the following methodology: Using the formula N = where Z = 1.15 (a 75% confidence level), S is the standard deviation, and R = 10% of the mean. OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent

Psychiatric DRGs lacking sufficient volume, OMAP sets a relative weight using:

(A) OMAP non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

(c) When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally derived weight for that DRG.

(d) Those relative weights based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State specific relative weights shall be adjusted, as needed, as determined by OMAP. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Indexed: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty (50) beds are reimbursed using the Diagnosis Related Grouper (DRG) as described in (2). Effective for services on or after:

(a) March 1, 2004, the Unit Value payment is 80% of the 2004 Medicare Unit Value and related data published in Federal Register/Vol.68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(b) August 15, 2005, the operating unit payment is 100% of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out of state hospitals do not receive the capital amount).

(7) Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients.

(b) For dates of service on and after March 1, 2004 the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270% of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, times;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270% of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, times;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50%), equals;

(vii) Cost Outlier Payment.

(E) Third party reimbursements are deducted from the OMAP calculation of payable amount;

(F) When hospital cost reports are audited, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and OMAP 42, adjusted to reflect the Medicaid mix of services.

(8) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. OMAP uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004 the Capital cost per discharge is one hundred (100) percent of the published Medicare capital rate for fiscal year 2004, see (5). The capital cost is added to the Unit Value and paid per discharge.(9) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct Medical Education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of TitleXIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX Direct Medical Education Cost per discharge;

(B) The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment.

(c) Direct Medical Education Payment Per Discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors.

(10) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to instate hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by

Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is the Office of Medical Assistance Program's indirect medical education factor. This factor is used for the entire Oregon fiscal year;

(d) For dates of service on and after March 1, 2004 the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case

Mix Index, multiplied by the hospital specific February 29, 2004 Unit Value, multiplied by the Indirect Factor equals the Indirect Medical Education Payment;

(e) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

Stat. Auth.: ORS 409

Stats., Implemented: ORS 414.065

8-15-05 (T)

410-125-0142 Graduate Medical Education Reimbursement for Public Teaching Hospitals -- Effective June 1, 1999

(1) Graduate Medical Education (GME) payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to non-Type A, Type B, and Critical Access inpatient acute hospitals based on the number of fee-for-service hospital inpatient discharges as provided in Direct Medical Education and Indirect Medical Education. Funding for public teaching hospital GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans. Since a significant portion of Medicaid payments for acute inpatient hospital discharges are made through managed care plans, an additional payment for GME is necessary to ensure the integrity and quality of medical training programs.

(2) The additional GME payment is a reimbursement to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. This reimbursement is in addition to that provided under Direct Medical Education and Indirect Medical Education.

(3) For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year).

(4) Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME.

(5) Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount -- other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable

costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

(6) The additional GME payment is calculated as follows:

(a) Total Title XIX GME is the sum of Title XIX IME and DME costs. Payments for Title XIX fee-for-service IME and DME are then subtracted from the Total Title XIX GME leaving the net unreimbursed Title XIX GME costs for the base year. The net unreimbursed Title XIX GME costs for the base year is then multiplied by HCFA Prospective Payment System (PPS) Hospital Index. The additional GME payment is rebased yearly.

(b) The additional GME reimbursement is made quarterly. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population.

(7) Total payments including the additional GME payments will not exceed that determined by using Medicare reimbursement. The Medicare upper limit will be determined from the most recent Medicare Cost Report and performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the additional GME payment is made.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

410-125-0145 Proportionate Share (Pro-Share) Payments for Public Academic Teaching Hospitals -- Inpatient

(1) Proportionate Share (Pro-Share) will be made to public academic teaching hospitals in the State of Oregon with 200 or more interns or residents. Pro-Share payments are subject to the federal Medicare upper payment limit for inpatient hospital payments. The Medicare upper payment limit analysis will be performed prior to making the payments.

(2) Eligible academic hospitals will be classified as either a:

(a) State owned or operated hospital; or

(b) Non-state government owned or operated hospital.

(3) The Pro-Share payment will be specific to each classification and determined as follows:

(a) The federal upper payment limit determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001;

(b) The Proportionate Share payment is calculated by the determination of Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments;

(c) The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data.

(4) Proportionate Share payments will be made quarterly during each federal fiscal year. Payments made during federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001 and quarterly for each federal fiscal year thereafter.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
10-1-01

410-125-0150 Disproportionate Share

(Effective for services rendered on or after January 1, 2001)

(1) The Disproportionate Share Hospital (DSH) payment is an additional reimbursement made to hospitals that serve a disproportionate share of low-income patients with special needs.

(2) A hospital's eligibility for DSH payments is determined at the beginning of each fiscal year. Hospitals that are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1.

(3) Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state:

(a) Criteria 1:

(A) The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) to total inpatient days is one or more standard deviations above the mean for all Oregon hospital;

(B) Information on total inpatient days is taken from the most recent audited Medicare Cost Report. The total paid Medicaid inpatient days is based on OMAP records for the same cost reporting period;

(C) Information on total paid Medicaid days is taken from Office of Medical Assistance Program (OMAP) reports of paid claims for the same fiscal period as the Medicare Cost Report.

(b) Criteria 2:

(A) A Low Income Utilization Rate exceeding 25 percent;

(B) The low income utilization rate is the sum of percentages (3)(b)(B)(i) and (3)(b)(B)(ii) below:

(i) The Medicaid Percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in a cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage;

(ii) The Charity Care Percentage: The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period, is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage;

(iii) Charity care is provided to individuals who have no source of payment, including third party and personal resources.

(C) Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other third party payers, such as FCHPs, Medicare, Medicaid, etc;

(D) The information used to calculate the Low Income Utilization rate is taken from the following sources:

(i) The most recent Medicare Cost Reports;

(ii) OMAP records of payments made during the same reporting period;

(iii) Hospital provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period;

(iv) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period;

(v) Any other information that OMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

(E) OMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

(c) Other Disproportionate Share Payment Calculations:

(A) To receive DSH payments, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital that performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital that had discontinued or did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify for disproportionate share payments, unless the hospital has, at a minimum, a Medicaid utilization rate of 1 percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another State are also accounted for;

(B) Information on total inpatient days is taken from the most recent Medicare Cost Report.

(d) Disproportionate Share Payment Calculations:

(A) Eligibility Under Criteria 1 -- The quarterly DSH payment to hospitals eligible under Criteria 1 is the sum of DRG weights for paid Title XIX non-Medicare claims for the quarter multiplied by a percentage of the hospital-specific Unit Value; this determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A, Type B, and

Critical Access Hospitals is set at the same rate as for out-of-state hospitals. The calculation is as follows:

(i) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5% to determine the DSH payment;

(ii) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. The amount is multiplied by 0.10 to determine the DSH payment.

(iii) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 0.25 to determine the DSH payment.

(B) Eligibility under Criteria 2 -- For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the payment is the sum of DRG weights for claims paid by OMAP in the quarter, multiplied by the hospital's disproportionate share adjustment percentage established under Section 1886(d)(5)(F)(iv) of the Social Security Act multiplied by the hospital's unit value;

(C) For out-of-state hospitals, the quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals that have entered into agreements with OMAP for payment are reimbursed according to the terms of the agreement or contract.

(e) Additional Disproportionate Share Adjustments:

(A) Public academic medical centers that meet the following eligibility standards shall be deemed eligible for additional DSH payments up to 100% of their cost for serving Medicaid fee for service clients and indigent and uninsured patients:

(i) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and

(ii) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(iii) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(B) 100% of the costs for hospitals qualifying for this DSH payment will be determined from the following sources:

(i) The most recent Medicare Cost Reports; or

(ii) OMAP's record of payments made during the same reporting period; or

(iii) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period; or

(iv) Any information which OMAP, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost.

(f) Disproportionate Share Payment Schedule:

(A) Hospitals qualifying for DSH payments under section (3)(d) will receive quarterly payments based on claims paid during the preceding quarter. Hospitals that were eligible during one fiscal year but are not eligible for disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (3)(c) will receive quarterly payments of 25 percent of the amount determined under this section;

(B) Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit" which is:

(i) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State plan, plus;

(ii) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

(C) The State has a contingency plan to assure that disproportionate share hospital payments will not exceed the "State Disproportionate Share Hospital Allotment." A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the "State Disproportionate Share Hospital Allotment."

(i) If the Allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (3)(e).

(ii) If the allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters.

(iii) If this second adjustment still results in the allotment being exceeded, hospitals qualifying for payments under section (3)(d) (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period.

(D) Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

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

10-1-04

410-125-0155 Upper Limits on Payment (UPL) of Hospital Claims

(1) Payments will not exceed total of billed charges:

(a) Upper limits on payment of claims does not apply to Proportional Share (Pro-Share) eligible academic hospitals, as defined in OAR 410-125-0145 and OAR 410-125-0215.

(b) The total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost outlier, capital, direct medical education, and indirect medical education payments shall not exceed the individual hospital's total billed charges for the period for these services;

(c) If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered;

(d) For Type A, Type B, and Critical Access Hospitals, reimbursement shall be limited to the lesser of allowable costs or billed charges. This limitation shall be applied separately to inpatient and outpatient services.

(2) Payments will not exceed finally approved plan:

(a) Total reimbursements to a state-operated facility made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan;

(b) Total aggregate inpatient reimbursements to all hospitals made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

410-125-0165 Transfers and Reimbursement

(1) When a patient is transferred between hospitals, the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate.

(2) The Per Diem Inter-Hospital Transfer Payment rate = the DRG payment divided by the geometric mean length of stay for the DRG. The geometric mean length of stay is reported in the DRG tables on the OMAP website.

(3) Payment to the transferring hospital will not exceed the DRG payment.

(4) The final discharging hospital receives the full DRG payment.

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

10-1-04

410-125-0170 Death Occurring on Day of Admission

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
11-18-91

410-125-0175 Hospitals Providing Specialized Outpatient Services

Some hospitals provide specific highly specialized outpatient services by arrangement with OMAP. Reimbursement is made according to the terms of a written agreement or contract.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065
11-18-91

410-125-0180 Public Rates

Rates billed to Office of Medical Assistance Programs (OMAP) cannot exceed the facility's public billing rate.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
10-1-91

410-125-0181 Non-Contiguous and Contiguous Area Out-of-State Hospitals - Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with OMAP regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under an OMAP fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

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

410-125-0190 Outpatient Rate Calculations—Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services which are based on the Office of Medical Assistance Programs (OMAP) fee schedule.

(b) Retrospective cost-based reimbursement is made for all covered outpatient services during the annual cost settlement period, except for the hospitals that have payment contracts with managed care plans.

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

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

10-1-04

410-125-0195 Outpatient Services In-State DRG Hospitals

DRG hospital outpatient services are reimbursed under a cost based methodology.

(1) Interim reimbursement:

(a) For dates of service on and after March 1, 2004 the interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges. The interim payment is the estimated percentage needed to achieve 80% of hospital cost in aggregate. This interim percentage is applied to all outpatient charges except for the following services: for laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management.

(b) The OMAP fee schedule is used as interim reimbursement for laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services.

(2) Settlement reimbursement:

(a) For Title XIX/Title XXI clients; an adjustment to 80 percent of outpatient costs for dates of service on and after March 1, 2004. This adjustment is made during the cost settlement process.

(b) For GA clients; outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-05

410-125-0200 Time Limitation for Submission of Claims

Office of Medical Assistance Programs (OMAP) will accept a claim up to 12 months after the date of service. The date of discharge is the date of service for an inpatient hospital claim.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
10-1-91

410-125-0201 Independent ESRD Facilities

(1) Independent End Stage Renal Dialysis (ESRD) Facilities: ESRD Facilities are reimbursed for Continuous Ambulatory Peritoneal Dialysis (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemodialysis Composite at 80% of the Medicare allowed amount, except for Epoetin. Epoetin is reimbursed at 100% of the Medicare maximum allowed amount.

(2) Other dialysis related charges which are allowed by Medicare, are reimbursed at 80% of the Medicare maximum allowed amount. Allowable laboratory charges are reimbursed according to the OMAP fee schedule. Billed charges may not exceed the Medicare maximum allowable amount.

(3) OMAP (Office of Medical Assistance Programs) follows Medicare's criteria for coverage of Epoetin, Intradialytic Parenteral Nutrition services, and the frequency schedule for laboratory tests for ESRD services. When laboratory tests are performed at a frequency greater than specified by Medicare, the additional tests must be billed separately, and are covered by OMAP only if the tests are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-99

410-125-0210 Third Party Resources and Reimbursement -- Effective for Hospital Services Provided On or After July 1, 1991

(1) The Office of Medical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the OMAP maximum allowable payment.

(2) OMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the OMAP reimbursement. OMAP will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

(3) When Medicare is Primary:

(a) OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient and Outpatient Rates Calculations Sections above;

(b) Payment is the OMAP allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries OMAP does not make any reimbursement for a service which is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries OMAP payment is the OMAP allowable, less the Part A payment up to the amount of the deductible due for services by either Medicare or Medicaid.

(4) When Medicare is Secondary:

(a) An individual admitted to a hospital may have Medicare Part B, but not Part A. OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations Section above. Payment is the OMAP allowable payment, less the Medicare Part B payment;

(b) An individual receiving services in the outpatient setting may have most services covered by Medicare Part B. OMAP payment is the OMAP allowable payment, less the Part B payment, up to the amount of the

coinsurance and deductible due. For services provided in the outpatient setting which are not covered by Medicare, (for example, Take Home Drugs), OMAP payment is the OMAP allowable payment as calculated in the Outpatient Rates Calculation Section above;

(c) Most Medicare-Medicaid clients have Medicare Part A, Part B, and full Medicaid coverage. OMAP refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. OMAP refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, OMAP does not make reimbursement for a service which is a not-covered service for Medicare.

EXAMPLE: Take home drugs are a not-covered Medicare service. OMAP will not make reimbursement for take home drugs provided to Qualified Medicare Beneficiaries.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services which are not covered by Medicare if those services are covered by OMAP.

EXAMPLE: Take home drugs are a not-covered Medicare service. Take home drugs are a covered OMAP service. OMAP will make reimbursement for take home drugs provided to Qualified Medicare- Medicaid Beneficiaries.

(5) Clients with PCO or HMO Coverage. OMAP payment is limited to those services which are not the responsibility of the PCO or HMO. Payment is made at OMAP rates.

(6) Other Insurance:

(a) OMAP pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) OMAP will make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the OMAP reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the OMAP maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
11-18-91

410-125-0220 Services Billed on the Electronic 837I or on the Paper UB-92 and Other Claim Forms

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional claim form) or on the paper UB-92.

(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper UB-92 along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by OMAP through direct medical education or indirect medical education payments and may not be billed on the electronic 837I or paper UB-92.

(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper UB-92 claim:

(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. Office of Medical Assistance Programs (OMAP) will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. OMAP will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper UB-92.

(5) Orthotics, prosthetics, durable medical equipment and implants:

(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper UB-92, along with all other inpatient services. The hospital is responsible for reimbursing the provider. Office of Medical Assistance Programs (OMAP) will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the Durable Medical Equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and Home Parenteral/ Enteral Services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-92, except home parenteral and enteral services and medications provided to patients who are in nursing homes:

(a) Home parenteral and enteral services, including home hyperalimentation, Home IV Antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral rules (Chapter 410 Division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services rules (Chapter 410 Division 121.

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper UB-92. Reimbursement for dental services provided by hospitals is restricted to those identified in the Dental Services rules (Chapter 410 Division 123 as covered services.

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper UB-92 as described in these rules and instructions and will be reimbursed at the hospital's interim rate.

(9) Maternity case management:

(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical rules (Chapter 410 Division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper UB-92; and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Home Health Care Services rules (Chapter 410 Division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to OMAP for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. OMAP will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation rules (Chapter 410 Division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper UB-92 with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and OMAP cost report.

(b) The services of supervising faculty physicians are not to be billed to OMAP on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper UB-92 if the hospital elects to report the cost of these

professional services as a direct medical education cost on the Medicare and OMAP cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (Chapter 410 Division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

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

04-01-05

410-125-0221 Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, direct and indirect medical education, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
11-18-91

410-125-0360 Definitions and Billing Requirements

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.

(2) Inpatient services are services to patients who typically are admitted to the hospital before midnight and listed on the following day's census, with the following exceptions:

(a) A patient admitted and transferred to another acute care hospital on the same day is considered an inpatient;

(b) A patient who expires on the day of admission is an inpatient; and

(c) Births.

(3) Outpatient services:

(a) Outpatient services are services to patients who are treated and released the same day;

(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short-term stay bed;

(c) Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation will be reimbursed. An outpatient observation stay that exceeds 48 hours must be billed as inpatient; and

(d) Outpatient observation services do not include the following:

(A) Services provided for the convenience of the patient, patient's family or physician but which are not medically necessary;

(B) Standard recovery period; and

(C) Routine preparation services and recovery for diagnostic services provided in a hospital outpatient department.

(4) Outpatient and inpatient services provided on the same day: If a patient receives services in the emergency room or in any outpatient setting and is admitted to an acute care bed in the same hospital on the same day, combine the emergency room and other outpatient charges related to that admission with the inpatient charges. Bill on a single UB-92 for both inpatient and outpatient services provided under these circumstances:

(a) If on the day of discharge, the client uses outpatient services at the same hospital, these must be billed on the UB-92 along with other inpatient charges, regardless of the type of service provided or the diagnosis of the client. Prescription medications provided to a patient being discharged from the hospital may be billed separately as outpatient Take Home Drugs if the patient receives more than a three-day supply.

(b) Inpatient and outpatient services provided to a client on the same day by two different hospitals will be reimbursed separately. Each hospital will bill for the services provided by that hospital.

(5) Outpatient procedures which result in an inpatient admissions: If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in Form Locator 19 (Type of Admission). The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.

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

10-1-04

410-125-0400 Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility, such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges and all charges for services must be submitted on a single UB-92 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care, the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When OMAP receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, OMAP will assume that a transfer has occurred. OMAP will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that OMAP made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction, from rehabilitative care to acute care, are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting should not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
12-1-93

410-125-0401 Definitions: Emergent, Urgent, and Elective Admissions

(1) EMERGENT ADMISSION -- an admission which occurs after the sudden onset 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:

(a) Placing their health or the health of an unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which could not be delayed by 24 hours.

(2) URGENT ADMISSION -- an admission which occurs for evaluation or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

(3) ELECTIVE ADMISSION -- an admission which is or could have been scheduled in advance and for which a delay of 72 hours or more in the delivery of medical treatment or diagnosis would not have substantially affected the health of the patient. See Prior Authorization section of the Hospital Services guide for requirements.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
4-1-01

410-125-0410 Readmission

(1) A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. The Office of Medical Assistance Programs (OMAP) will make one payment for the combined service. Examples of planned readmissions include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

(2) A patient whose discharge and readmission to the hospital is within fifteen (15) days for the same or related diagnosis must be combined into a single billing. OMAP will make one payment for the combined service.

(3) This rule does not apply to:

(a) Readmissions for an unrelated diagnosis;

(b) Readmissions occurring more than 15 days after the date of discharge;

(c) Readmissions for a diagnosis that may require episodic (a series) acute care hospitalizations to stabilize the medical condition such as, but not limited to: diabetes, asthma, or chronic obstructive pulmonary disease.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

04-01-05

410-125-0550 X-Ray or EKG Procedures Furnished in Emergency Room

OMAP pays for only one interpretation of an x-ray or EKG procedure furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient. A second interpretation of an x-ray or EKG is considered to be for quality control purposes only, and is not reimbursable. Payment will be made for a second interpretation only under unusual circumstances, such as questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

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

10-1-00

410-125-0600 Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact OMAP for information on enrollment.

(3) Billings are sent to Office of Medical Assistance Programs.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to OMAP along with documentation supporting the emergent or urgent requirement for treatment.

(5) In a non-emergency situation, prior authorization is required for all services. Contact: OMAP.

(6) Claims must be billed on the UB-92, unless other arrangements are made for billing through the OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
12-1-93

410-125-0620 Special Reports and Exams and Medical Records

Refer to the OMAP Administrative Exams and Reports Billing rules (Chapter 410 Division 150) for information and instructions on billing for administrative exams and reports.

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

10-1-04

410-125-0640 Third Party Payers -- Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to OMAP until they have been billed to and adjudicated by Medicare:

(a) Exception: Take home drugs and other services, which are not covered by Medicare, may be billed directly to OMAP without billing Medicare first;

(b) See: billing instructions in the Hospital Services Supplemental Information on OMAP's website for additional information on billing Medicare claims.

(2) Other Insurance. With the exception of services described in the General Rules, bill all other insurance first before billing OMAP. Report the payments made by the other insurers.

(3) Motor vehicle accident fund:

(a) Enter 01 (Auto Accident) in the Occurrence Code Block (Form Locator 32 – 35) and give the date of the accident;

(b) For all other clients, bill all other resources before billing OMAP. Do not bill the Motor Vehicle Accident Fund.

(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in Form Locators 32 – 35 and give the date of occurrence.

(5) Liability:

(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;

(b) The provider may bill the insurer for liability prior to billing OMAP. The provider may not bill both OMAP and the insurer;

(c) The provider may bill OMAP after receiving a payment denial from the insurer; however, the OMAP billing must be within 12 months of date of service. Payment accepted from OMAP is payment in full;

(d) The provider may bill OMAP without billing the liability insurer. However, payment accepted from OMAP is payment in full. The payment made by OMAP may not later be returned in order to pursue payment from the liability insurer. When the provider bills OMAP, the provider agrees not to place any lien against the client's liability settlement;

(e) The provider has 12 months from the date of service to bill OMAP. No payment will be made by OMAP under any circumstances once the one year limit has passed if no billing has been received within that time.

(6) Adoption Agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, OMAP makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. OMAP may also make reimbursement for services provided to the infant. Some adoption agreements, however, stipulate that the adoptive parents will make payment for part or all of the medical costs for the mother and/or the child. In these instances, the adoptive parent(s) and/or agency are a third party resource and should be billed before billing OMAP for this service.

(7) Veteran's Administration Benefits:

(a) Some clients have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA covered services before billing OMAP;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(8) Trust Funds. Some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other

trusts which pay medical expenses, are considered a prior resource. Bill the trust fund prior to billing OMAP for services that are covered by the trust fund.

(9) Billing the Client. A provider may bill the client or any financially responsible relative or representative of that individual only as allowed in OAR 410-120-1280.

(10) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by OMAP;

(b) For services for which OMAP has made payment;

(c) For services billed to OMAP for which no payment is made because third party reimbursement exceeds the OMAP maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which OMAP has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to OMAP to allow processing of the claim in a timely manner as described in these rules and the General Rules;

(B) The hospital failed to obtain prior authorization as described in these rules;

(C) The service provided by the hospital was determined by or OMAP not to be medically appropriate; or

(D) The service provided by the hospital was determined by the QIO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 10-1-04

410-125-0641 Medicare

(1) A Medicare/Medicaid claim can automatically be sent to OMAP after adjudicated by Medicare. This saves the effort of a second submission, as well as ensuring a more accurate and speedier payment by the Office of Medical Assistance Programs (OMAP). Medicare will automatically transmit the correct Medicare payment, coinsurance, and deductible information to OMAP.

(2) Hard copy billings sent to Medicare can also be automatically sent to OMAP. Refer to the Hospital Services Supplemental Information for specific billing instructions.

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

10-1-04

410-125-0720 Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a UB-92. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support the request. Attach a copy of the claim and Remittance Advice. Adjustment requests must be submitted in writing to Office of Medical Assistance Programs.

(3) Complete adjustment instructions can be found in Hospital Services Supplemental Information.

Stat Auth.: ORS 184.750, 184.770, Ch. 411 & 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-1020 Filing of Cost Statement

(1) The hospital must file with Office of Medical Assistance Programs (OMAP), an annual Calculation of Reasonable Cost (OMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with OMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the OMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient laboratory, radiology services, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(2) Twelve months after the hospital's fiscal year end, OMAP will send the hospital a computer printout listing all transactions between the hospital and OMAP during that auditing period. The Calculation of Reasonable Cost statement (OMAP 42) is due within 90 days of receipt by the hospital of the computer printout. Failure to file within 90 days may result in a 20 percent reduction in the payment rate.

(a) Hospitals without an agreement with Medicare may be subject to a field audit;

(b) Hospitals without an agreement with Medicare are required to submit a financial statement giving details of all assets, liabilities, income, and expenses, audited by a Certified Public Accountant.

(3) Improperly completed or incomplete Calculation of Reasonable Cost statements will be returned to the hospital for proper completion. The

statement is not considered to be filed until it is received in a correct and complete form.

(4) If a hospital knowingly, or has reason to know, files a cost statement containing false information, such action constitutes cause for termination of its agreement with OMAP. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(5) Each Calculation of Reasonable Cost statement submitted to OMAP must be signed by the individual who normally signs the hospital's Medicare reports, federal income tax return, and other reports. If the hospital has someone other than an employee prepare the cost statement, that individual will also sign the statement and indicate his or her status with the hospital.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-99

410-125-1040 Accounting and Record Keeping

(1) All records for a given fiscal period must be kept for three years after the Medicare audit for that period has been finalized.

(2) Each hospital is required to make its financial records available for auditing within the state of Oregon at a location specified by the provider.

(3) All hospital records are subject to inspection and review by Office of Medical Assistance Programs (OMAP) personnel and Department of Health and Human Services (HHS) personnel during the period the records are required to be held.

(4) All expenses must be documented in detail as a part of the record. All capital expenditures requiring approval under the Certificate of Need process, and not having such approval, will be disallowed.

(5) Hospitals without a Medicare agreement must use the Hospital Administrative Services (HAS) system of reporting.

(6) Record keeping and reporting must be based on date of service, not date of payment. Billings for patients determined by OMAP to be eligible for Title XIX or Program 5 must be included as accruals, even those billings not yet paid.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
10-1-91

410-125-1060 Fiscal Audits

(1) Year-end fiscal audits will include retrospective examination and verification of claims and the determination of allowable charges and costs of hospital services provided to Office of Medical Assistance Programs (OMAP) clients.

(2) The principal source document for the fiscal audit of Title XIX/Title XXI and General Assistance patient billings and payments for a given fiscal period is the OMAP data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from OMAP records, information received from the hospital, and other sources, OMAP will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (OMAP 42) will be prepared using revised totals and information from the Medicare report.

(3) Cost Settlements: OMAP will send the hospital a letter stating the amount of underpayment or overpayment calculated by OMAP for the fiscal year examined. The letter will also state the hospital's inpatient/outpatient interim reimbursement rate for the period from the effective date of the change until the next fiscal year's audit is completed. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter.

(4) OMAP, at its discretion, may grant a thirty (30) day extension for the purpose of reviewing the cost settlement upon a written request by the hospital. If a thirty (30) day extension is granted, payment of the cost settlement amount is due within sixty (60) days from the date of the letter. If the provider chooses to appeal the decision or rate, a written request for an administrative review, or contested case must be received by OMAP within thirty (30) days of the date of the letter notifying the hospital of the settlement amount and interim rate, or within sixty (60) days if OMAP has granted a thirty (30) day extension, not withstanding the time limits in OAR 410-120-1580(3) or 410-120-1660(1). Upon receipt of the request, OMAP will attempt to resolve any differences informally with the provider before scheduling the administrative review or hearing.

(5) Under extraordinary circumstances, OMAP, at its discretion, may negotiate a repayment schedule with a hospital. The hospital may be required to submit additional information to support the hospital's request for a repayment schedule. The hospital will be required to pay interest associated with extended payments granted by OMAP.

(6) The revised Calculation of Reasonable Cost, copies of adjustment schedules, and a copy of the printout are available to the hospital upon request. For Type A rural hospitals the Calculation of Reasonable Cost Statement will reflect the difference between payment at 100% of costs and payment under the fee schedule for laboratory and radiology services provided by the hospital. An adjustment to the Cost Settlement will be made to reimburse a Type A hospital at 100% of costs for laboratory and radiology services provided to Medical Assistance Program clients during the period the hospital was designated a Type A hospital. Settlements to Type B and Critical Access hospitals will be made within the legislative appropriation.

(7) The adjusted Professional Component Cost-to-Charge ratio(s) will be applied to all corresponding revenue code charges as listed on the Hospital Claim Detail Reports for cost settlements finalized on or after October 1, 1999.

(8) Hospital Based Rural Health Clinics shall be subject to the rules in the Hospital Services for the Oregon Health Plan Guide for Type A and B Hospitals. Hospital Based Rural Health Clinics cost settlements shall be finalized using the lower of cost or charges principle.

(9) No interim settlements will be made. No settlements will be made until after receipt and review of the audited Medicare cost report.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

410-125-1070 Type A and Type B Hospitals

(1) Type A and Type B hospitals must submit the following information to the Office of Medical Assistance Programs (OMAP):a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and(b) The amount of payment received by the hospital, from each OMAP contracted managed care plan and third-party payers, for inpatient and outpatient hospital services provided to managed care members, within the hospital's fiscal year.

(2) When a hospital is contracted with a Managed Care Organization (MCO), within thirty (30) days of OMAP's request the hospital will supply OMAP the following information:

(a) The name of the contracting MCO; and

(b) The dates for which the contract will be effective; and

(c) The contracted services and reimbursement rates.

(3) The hospital and MCO must coordinate payment information to verify and return the MCO payment data file sent by OMAP within ninety (90) days from date the data file is received by the hospital.

(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No sanction or fine will be imposed if OMAP determines, at its sole discretion, that the hospital was unable to coordinate payment information with the MCO through no fault of the hospital's own.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 7-1-05

410-125-1080 Documentation

(1) Federal regulations require Medicaid providers to maintain records that fully support the extent of services for which payment has been requested, and that such records be furnished to Office of Medical Assistance Programs (OMAP) upon request (42 CFR 431.107).

(2) All applicants for Title XIX or general assistance complete Form OMAP 415A or 415B authorizing the release of any records regarding his or her health. When requested by OMAP or its medical review contractor, hospitals must submit sufficient medical documentation to verify the emergency nature, medical necessity, quality and appropriateness of treatment, and appropriateness of the length of stay for inpatient and outpatient hospital services. OMAP may request sufficient information to evaluate the accuracy and appropriateness of ICD-9-CM Coding for the claim. In addition, OMAP may request an itemized billing for all services provided. OMAP will specify in its request what documentation is required

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

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
7-9-90

410-125-2000 Access to Records

(1) Providers must furnish requested medical and financial documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days will result in recovery of payment(s) made by Office of Medical Assistance Programs (OMAP) for services being reviewed.

(2) OMAP contracts with a Quality Improvement Organization (QIO) to conduct post payment review of admissions and claim records. The QIO may request records from a hospital or may request access to records while at the hospital. The QIO has the same right to medical information as OMAP.

(3) The hospital has 30 days to provide OMAP or the QIO with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Medical Payment Recovery Unit (MPRU) conducts recovery activities for OMAP involving third party liability resources. MPRU may request records from the hospital. This unit has the same right to medical and financial information as OMAP.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-2020 Post Payment Review

(1) All services provided by a hospital in the inpatient or outpatient setting are subject to post-payment review by Office of Medical Assistance Programs (OMAP) or the contracted Quality Improvement Organization (QIO). Both emergency and non-emergency services may be reviewed. Claims for services may be reviewed to determine:

(a) The medical necessity of the admission or outpatient services provided;

(b) The appropriateness of the length of stay;

(c) The appropriateness of the plan of care;

(d) The accuracy of the ICD-9 coding and DRG assignment;

(e) The appropriateness of the setting selected for service delivery;

(f) The quality of care of the services provided;

(g) The nature of any service coded as emergent;

(h) The accuracy of the billing;

(i) The care furnished is appropriately documented.

(2) If the QIO determines that a hospital service was not within OMAP coverage parameters, the hospital and attending physician will be notified in writing and will have twenty days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(3) If the recommendation for denial is upheld by the reviewing contracted QIO, the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(4) If the reconsidered decision is to uphold the denial, payment to all providers of service will be recovered.

(5) The hospital and/or practitioner may appeal any final decision through the OMAP administrative appeals process.

(6) No payment will be made by OMAP for inpatient services if the QIO or Medicare has determined the service is not medically necessary and/or appropriate.

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

10-1-04

410-125-2030 Recovery of Payments

(1) Payments made by OMAP will be recovered for:

(a) Services identified by the provider as emergent or urgent, but determined on retrospective review not to have been emergent or urgent. Payment will also be recovered from the admitting and/or performing physician;

(b) Services determined by OMAP's contracted Quality Improvement Organization (QIO) that the readmission to the same hospital was the result of a premature discharge;

(c) Services were billed but not provided;

(d) Services provided at an inappropriate level of care, which includes the setting selected for service delivery;

(e) OMAP non-covered services;

(f) Services, which were covered by a third party payer or other resources; or

(g) Services denied by a third party payer as not medically necessary.

(2) Payment to a physician and other providers of service for inpatient non-urgent or non-emergent services requiring prior authorization is subject to recovery by OMAP if recovery is made from the hospital.

(3) If review by OMAP results in a denial, the hospital may appeal any final decision through the OMAP Administrative Appeals process. See Administrative Hearings (Chapter 410 Division 120).

(4) As part of the Utilization Review Program, OMAP and/or its Contractor will develop and maintain a data system profiling the patterns of practice of institutions and practitioners. As a result of these profiles, OMAP may initiate focused reviews. Any practitioner or hospital subject to a focused review will be notified in advance of the review.

(5) All providers having a pattern of inappropriate utilization or inappropriate quality of care according to the current standards of the medical community and/or abuse of OMAP rules or procedures, will be subject to corrective action. Actions taken will be those determined appropriate by OMAP, the QIO, or sanctions established under the Oregon Revised Statues (ORS) or Oregon Administrative Rule and/or referral to a State or Federal authority, licensing body or regulatory agency for appropriate action.

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

10-1-04

410-125-2040 Provider Appeals -- Administrative Review

(1) A provider may request an administrative review regarding the decision(s) by the Office of Medical Assistance Programs (OMAP) that affect the services they provide or have provided. See General Rules (Chapter 410 Division 120).

(2) A requests for an Administrative Review must be submitted in writing to the Medicaid Administrator, 500 Summer Street NE, E49, Salem, OR 97301-1079.

(3) The request must be received within 30 days of the date of notification of the payment decision or notification of change in reimbursement.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-2060 Provider Appeals -- Hearing Request

If the hospital disagrees with the Office of Medical Assistance Programs (OMAP) calculation of reasonable costs for outpatient services or inpatient services, the outpatient interim rate, DRG based prospective payment for inpatient services, the calculation of the hospital's unit value, or any other hospital reimbursement methodologies or payments, a written request for an appeal may be made to OMAP in accordance with the General rules (Chapter 410 Division 120). A hearing request must be received not later than 30 days following the date of the notice of action. At the time of appeal, the hospital must submit any data the hospital wants OMAP to consider in support of the appeal. The appeal will be conducted as described in General rules.

Stat. Auth.: ORS 184.750, ORS 184.770 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04

410-125-2080 Administrative Errors

(1) If a hospital has been given incorrect information by Office of Medical Assistance Programs, Children, Adults, and Families Programs, or Seniors and People with Disabilities / staff, and services were provided on the basis of this information, and payment has been denied as a result, the hospital may submit a request for payment as an Administrative Error.

(2) Include the following:

(a) An explanation of the problem;

(b) Any documents supporting the request for payment;

(c) A copy of any Remittance Advice printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Office of Medical Assistance Programs, Provider Inquiry, Administrative Errors, 500 Summer Street NE, E-44, Salem, OR 97301-1077.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065

10-1-04