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To: OMAP Hospital Providers

From: Joan M. Kapowich, Manager
OMAP Program and Policy Section

Joan M. Kapowich

Subject: Hospital Services Administrative Rules, Revision 5

Effective: September 1, 2004

The Hospital Services Program Rulebook is revised as follows:

OMAP temporarily amended OAR 410-125-0047 to clarify the language and to assist hospitals and managed care organizations in the administration of the limited hospital benefit for clients who are eligible for OMAP's Standard Benefit package.

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

- If you do not have web access and receive hardcopy of revisions, this letter is attached to the revised rule for replacement in your Hospital Rulebook. Each rule is numbered individually for easy replacement.

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

TR 560 9/1/04

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 125

Hospital Services

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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 ACES each time services are provided in order to assure that the client is eligible. Call the ACES Hotline (1-800-422-7012) for assistance with ACES.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 409.010
10-1-91

410-125-0020 Retroactive Eligibility

(1) 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 for service*. However authorization for payment may be given after the service is provided under some circumstances. See the Prior Authorization Section for further information.

* See OAR 410-125-0102 for exception for Medically Needy Program clients.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414
Stats. Implemented: ORS 409.010
10-1-91

410-125-0030 Hospital Hold

(1) A hospital hold is a process which allows an in-state general hospital, out-of-state contiguous general hospital or in-state Critical Access 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.

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

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

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 Basic Benefit package. See the General Rules for more information on eligibility, benefit package, and covered services. Most Title XIX/Title XXI clients are enrolled in an FCHP, an MHO and a DCO. Some Title XIX clients are Medicare Beneficiaries. Some Title XIX clients are in the Medically Needy Program.

(2) FCHP, MHO, and DCO Clients The Office of Medical Assistance Programs (OMAP) contracts with Prepaid Health Plans: 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) Prepaid Health Plan clients receive most of their primary care services through the FCHP or upon referral from the FCHP. 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 for emergency and non-emergency services. For

more information, see the section on Prior Authorization and Billing in the Hospital Services Guide.

(f) OMAP will not reimburse for services which can be provided by the client's prepaid health plan (PHP) and which 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 for information on eligibility. See the Hospital Services guide on Billing and Reimbursement for further information on billing.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
10-1-99

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. See the Reimbursement section for further information.

(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 any prepaid health plans. The state will contact the hospital regarding billing instructions for these clients.

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

410-125-0045 Coverage and Limitations

In general, most medically appropriate services are covered for all clients. 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 which apply to hospital services are:

(1) Prior Authorization: Some services require prior authorization. Check the Prior Authorization section for further information.

(2) Non-Covered Services:

(a) Services which are not medically appropriate, for which medical efficacy has not been proven, or services which 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;

(c) See the General Rules and other provider guides for a list of not-covered services. Further information on some not-covered services is found in the Revenue Code section of the Hospital Service guide.

(3) Limitations on Hospital Benefit Days: Clients have no hospital benefit day limitations for treatment of services identified as covered on the Prioritized List of Health Services (OAR 410-141-0520).

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

(5) Services Provided Outside of Facility: Services which are delivered 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
10-1-00

410-125-0047 Limited Hospital Benefit Package 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: http://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

9-1-04 (T)

410-125-0050 Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-03

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 which may require prior authorization include:

(a) Physical Therapy;

(b) Occupational Therapy;

(c) Speech Therapy;

(d) Audiology;

(e) Hearing Aids;

(f) Dental Procedures;

(g) Drugs;

(h) Apnea monitors, services, and supplies;

(i) Out-of-state services;

(j) Home Parenteral/Enteral Therapy;

(k) Durable Medical Equipment and Medical supplies;

(l) Certain surgical procedures;

(m) See more specific guidelines below.

(2) 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 OMPRO 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) All other 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 OMPRO (unless indicated otherwise in OAR 410-125-0080).

(3) Occupational therapy, physicial therapy, speech therapy, audiology:

(a) For prior authorization of services for AFS and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(A) SDSD clients not enrolled in an FCHP -- Contact the Senior and Disabled Services Division branch.

(B) FCHP clients -- Contact the plan.

(b) Exceptions: Medicare clients enrolled in FHCPs -- 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 payment. See OAR 410-125-0103.

(c) Occupational therapy, physical therapy, speech therapy and audiology services provided in the outpatient hospital settings are subject to the limitations established in the appropriate provider guides.

(4) Hearing aids:

(a) For prior authorization of services for AFS and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(b) SDSD clients not enrolled in an FCHP -- Contact the Senior and Disabled Services Division branch.

(c) FCHP clients -- Contact the client's FCHP.

(5) Dental Procedures Provided in a Hospital Setting:

(a) For AFS, SDSD, and SCF clients not enrolled in an FCHP -- Contact: OMAP Dental Program Coordinator.

(b) FCHP clients -- Contact the client's FCHP.

(c) Exceptions: Emergency dental procedures do not require prior authorization.

(6) Durable Medical Equipment and Medical Supplies:

(a) For prior authorization of services for AFS and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(b) SDSD clients not enrolled in an FCHP -- Contact the Senior and Disabled Services Division branch.

(c) For FCHP clients -- Contact the client's FCHP. Costly Durable Medical Equipment items, such as wheelchairs, generally require prior authorization. Smaller items, such as medical supplies, may not require prior authorization. A complete list of items which require prior authorization is available in the Durable Medical Equipment and Medical Supplies Guide.

(d) Durable medical equipment and medical supplies in the outpatient hospital setting are subject to the limitations established in the Durable Medical Equipment and Medical Supplies Provider Guide.

(7) APNEA monitors, services, and supplies:

(a) For AFS, SDSD and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(b) For FCHP clients -- Contact the client's FCHP.

(8) 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.

(9) Home parenteral/enteral therapy.

(a) Home Parenteral/Enteral Therapy includes: home hyperalimentation (TPN), home enteral nutrition, home IV antibiotics, home IV analgesics, home IV chemotherapy, home IV hydrational fluids, home IV-other drugs.

(b) OMAP does not cover home enteral/parenteral therapy as a hospital service. Hospital-based home health agencies and retail pharmacies which are enrolled by OMAP with separate provider numbers can provide home enteral/parenteral therapy. These services are not billed on the UB-92 form. Please see the Home Enteral/Parenteral Nutrition and IV Services provider guide for coverage and prior authorization rules.

(10) Drugs:

(a) A few medications, such as human growth hormone and Isotretinoin require prior authorization when provided in the outpatient setting. See the Pharmaceutical Services Guide for a complete list of drugs requiring prior authorization.

(b) For FCHP Clients -- Contact the client's FCHP.

(c) Medications provided in an emergency do not require prior authorization.

(11) Private duty nursing:

(a) For AFS and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(b) SDSD clients not enrolled in an FCHP -- Contact the Senior and Disabled Services Division branch.

(c) For FCHP clients: FCHP clients -- Contact the FCHP.

Note: See the Private Duty Nursing Services guide for additional information.

(12) Home health services:

(a) For AFS and SCF clients not enrolled in an FCHP -- Contact the OMAP Medical Unit.

(b) SDSD clients not enrolled in an FCHP -- Contact the Senior and Disabled Services Division branch.

(c) FCHP clients -- Contact the FCHP.

Note: See OAR 410-123-0220 and the Home Health Services guide for additional information.

(13) Augmentive Communication Devices:

(a) For AFS, SDSD and SCF clients not enrolled in an FCHP -- Contact OMAP Medical Unit.

(b) For FCHP clients -- Contact the client's FCHP.

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

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 OMPRO (Oregon Medical Professional Review Organization) Procedures

(1) The Office of Medical Assistance Programs (OMAP) approves or denies a request for non-emergency inpatient services based on recommendations from OMPRO's physician review findings. Requests to OMPRO for non-emergency inpatient hospital admissions may be submitted in writing or by phone.

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

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

(4) OMPRO staff have the right to require that a client seek a second opinion from a contracted second opinion physician if the appropriate criteria have not been met, or if adequate information has not been submitted by the physician. If the requesting physician disagrees with the opinion of the second opinion physician, OMPRO has the right to require that a client seek a third opinion. If the second opinion physician disagrees with the requesting physician, the requesting physician may ask OMPRO 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 OMPRO.

(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 during 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
10-1-00

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 Senior and Disabled Services Division (SDSD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with SDSD rules. Contact SDSD for further information.

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

410-125-0102 Medically Needy Clients

(1) OMPRO 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
10-1-91

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 these rules apply.

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

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 rules for additional information.

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

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 Billing Section in the Hospital Services guide for further information.

(2) Another insurer denied the claim because the service was 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 if the services are covered by Medicaid. See Billing Section of the Hospital Services provider guide for more information.

Stat. Auth.: ORS Ch 184
Stats. Implemented: ORS 414.065
10-1-99

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 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 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 cannot 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 of service from OMPRO or OMAP.

(4) Refer to the Quick Reference Prior Authorization Chart in the Hospital Services Guide for prior authorization information and contacts on specific services. Hospitals may also verify prior authorization by calling OMPRO or OMAP provider services.

Stat. Auth.: ORS 184.750, ORS 409.010, ORS 409.110, ORS 411 & ORS 414
Stats. Implemented: ORS 414.065
1-1-93

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 individual claims to a DRG category. Medicare revises the Grouper program each year in October. 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. Reweighting 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) Operating Costs:

(a) For the purposes of determining costs for all hospitals except for Type A, Type B, and Critical Access Hospitals , costs are defined as costs derived from the Medicare cost reports for the hospital FY ending during the State FY 87 (July 1, 1986 through June 30, 1987) adjusted to the Medicaid mix of services and trended forward using Data Resources Inc. (DRI) inflation factors;

(b) For the purposes of determining each hospital's unit value for services beginning July 1, 1991, the following procedure was used:

(A) The Medicaid cost per discharge was derived from each hospital's Medicare cost report as described above, and adjusted to the Medicaid mix of services. The costs of capital and direct and indirect medical education were deducted from this amount (capital and education costs were taken from the Medicare cost report for the hospital's fiscal year ending during the State 1987 Fiscal Year). The resultant amount is referred to as the "operating cost" per discharge;

(B) The operating cost per discharge as described in (5)(A) of this rule (Operating Costs) for each hospital was adjusted in order to bring all hospitals to the same 1987 mid-point, using HCFA-DRI inflation adjustments. The operating cost was then inflated forward to the mid-point of Oregon Fiscal Year 1992 (January, 1992) using the compounded CMS-DRI inflation factor.

(6) Unit Value: The Unit Value for each hospital effective for services beginning on or after July 1, 1991, was established as follows:

(a) The Oregon Fiscal Year 1992 operating cost per discharge was multiplied by the ratio of the projected 1992 CMI to the 1987 CMI to adjust for changes in the CMI between 1987 and the CMI for 1992;

(b) The CMI-trend adjusted cost per discharge is divided by the hospital's projected 1992 CMI in order to compare all hospitals as though they had a CMI of 1.0;

(c) All hospitals, including Type A, Type B, and Critical Access hospitals, are ranked by their CMI adjusted cost per discharge;

(d) Each hospital below the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to its CMI adjusted operating costs per discharge described in (5), Operating Costs. This preliminary FY 1992 Unit Value is reduced by the cost outlier payments which had been projected for FY 1992 (the projections which were the basis for the FY 1992 prospective rates). This preliminary unit value is further reduced by 2.45% to get the Final Unit Value for FY 1992. This shall also be the hospital's Unit Value for the period beginning December 1, 1993;

(e) Each hospital at or above the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to the Preliminary Unit Value of the hospital at the 70th percentile. This Preliminary FY 1992 Unit Value is adjusted downwards as required in order that the outlier payments which had been projected for FY 1992 combined with the Operational Payment will not exceed the hospital's FY 1992 Operating Cost per Discharge as described in (5), of this rule. This preliminary unit value is further reduced by 2.45% to get the final Unit Value for FY 1992. This shall also be the hospital's Unit Value for the period beginning December 1, 1993;

(f) For services beginning on or after October 1, 1996 the Unit Values for each hospital shall be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors.

(g) Effective for services provided on or after January 1, 2004, the Unit Value will revert to the rate in effect March 1, 2003.

(7) DRG Payment: The DRG payment to each hospital is calculated by multiplying the Relative Weight for the DRG by the Hospital-Specific Unit Value. This is also referred to as the Operational Payment.

(8) 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) Effective for services beginning on or after July 1, 1991, the calculation to determine the cost outlier payment for all 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 case load;

(C) If the hospital's net costs as determined above are greater than 300 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 300% 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) 300% 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.

(9) 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. The Office of Medical Assistance Programs uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Capital cost per discharge is calculated as follows:

(A) The capital cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare discharges. This results in the Title XIX Capital Cost per discharge. The Title XIX capital cost per discharge for each hospital above the 50th percentile will be set at the 50th percentile for Oregon hospitals receiving DRG reimbursement;

(B) The Title XIX Capital Cost per discharge for this period is inflated forward to Oregon FY 1992, using the compounded HCFA-DRI market basket adjustment.

(c) Capital Payment Per Discharge:

(A) The number of Title XIX discharges paid during the quarter for each hospital is multiplied by the Title XIX cost per discharge from 1987 trended forward as described above. This determines the current quarter's capital costs. Reimbursement is made at 85% of this amount. Payment is made within thirty days of the end of the quarter;

(B) The capital 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) 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 Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is 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.

(11) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to in-state 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) 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 Unit Value, multiplied by the Indirect Factor equals 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
1-1-04

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 which 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 which 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. 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 which 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 who 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 which 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 the Unit Value set 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 which 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 which 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
10-1-01

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 transfering hosital will not exceed the DRG payment.

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

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

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
10-1-01

410-125-0195 In State DRG Hospitals

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

(2) Settlement reimbursement:

(a) For Title XIX/Title XXI clients; an adjustment to 59 percent of outpatient costs 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

1-1-04

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 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 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 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 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 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;

(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 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 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 a 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 Guide;

(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 Guide.

(7) Dental Services. Dental services provided by hospitals are billed on the UB-92. Reimbursement for dental services provided by hospitals are restricted to those identified in the Dental Services Guide as covered services.

(8) End-State Renal Dialysis Facilities. Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the 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 Guide contains information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the UB-92;

(b) Providers must bill using Revenue Code 569 and the appropriate OMAP Unique Code (see the Medical-Surgical Guide for the codes).

(10) Home Health Care Services. Hospitals which operate home health care services must obtain a separate provider number and bill for these services in accordance with the Home Health Care Services Guide.

(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 HCFA-1500 in accordance with the rules and restrictions contained in the Medical Transportation Guide.

(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 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 HCFA-1500 or the 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;

(c) The services of supervising faculty physicians are billed on the HCFA-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 Program Provider Guide for additional information on billing on the HCFA-1500.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

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

410-125-0240 When to Bill on a Hard-Copy UB-92

(1) The hospital must bill on a hard-copy UB-92 in the following circumstances:

(a) When attachments are required;

(b) When re-billing a Medicare claim previously sent to Medicare. When the hospital bills Medicare the first time, the claim will "crossover" automatically to Medicaid by entering the Medicaid and client information on the third party payer screen. These claims will be forwarded on tape by Medicare to OMAP.

(2) Multiple page hard-copy UB-92s cannot be processed by OMAP. If the hard copy claim exceeds one page, the following procedures apply:

(a) Outpatient: Separate the charges into two claims. Do not duplicate Revenue Codes or HCPCS codes unless billing different dates of service and the different dates of service are shown in Form Locator 45. For example, if the Revenue Code 250 (Pharmacy) appears on one claim, it must not appear on the second claim unless the services were provided on different dates and the dates of service are shown in Form Locator 45.

(b) Inpatient: Do not separate the charges into two claims. Collapse several services into a single revenue code if needed to reduce the total number of line items to 22 or less. Do not use more than 22 revenue codes or line items on an inpatient claim.

(3) The limit on electronic claims is 28 line items.

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

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

410-125-0260 When Attachments are Required

When attachments are required, the claim must be submitted on a hard-copy (paper) UB-92. Attachments for the following must be submitted:

(1) Retroactive Medical: Documentation showing medical appropriateness for non-emergent services must be attached to the UB-92 if the patient becomes eligible retroactive to the date the services were provided.

EXCEPTION: Attachments are not required on claims for obstetrical and newborn services.

(2) Unlisted Lab, Radiology, Nuclear Medicine, CT Scans, MRI and Other Imaging Services Codes: Unlisted codes are manually priced by the Medical Group. Documentation describing the test or procedure performed is necessary to determine the appropriate payment. Send the claim with the description of the test or the procedure to OMAP.

(3) Claims over twelve months old:

(a) If the claim is more than 12 months old and has been billed previously to OMAP, submit a corrected copy of the claim, along with all remittance advice and any other information (such as payment information from another payer) necessary to review the claim;

(b) Claims more than 15 months old will not be accepted unless the branch or OMAP has made an error which resulted in a denial of payment, an incorrect payment, or the failure of the provider to bill within the 12 month limit. See General Rules for restrictions on submission of claims. Send claims to OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

410-125-0360 Definitions and Billing Requirements

(1) 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.

(c) Births.

(2) 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 which exceeds 48 hours must be billed as inpatient.

(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;

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

(3) 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.

(4) Outpatient Procedures Which Result In 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.

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

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

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

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) Readmissions occurring more than 15 days after the date of discharge or for an unrelated diagnosis are not subject to this rule.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
4-1-2004

410-125-0500 Other Outpatient Services:

Laboratory Services, Diagnostic and Therapeutic Radiology, Nuclear Medicine, CT Scans, MRI, and Other Imaging Services

(1) Hospitals must use HCPCS/CPT-4 codes. No modifiers are needed;

(2) Bill the Technical Component under Revenue Codes 300-359, 400-409, 610-619, 923 and 925. Do not use modifiers;

(3) Bill the Prefessional Component under Revenue Codes 970 to 974. Do not use modifiers. The professional component for CT Scans and MRIs should be billed under 972.

(4) Bill using the most appropriate HCPCS/CPT-4 code. Do not fragment or unbundle laboratory services. Refer to the Medical-Surgical Guide for additional information.

(5) A hospital may bill the Office of Medical Assistance Programs (OMAP) for the collection of blood through venipuncture, capillary puncture, or the collection of a urine sample by catheterization. These services, however, will not be reimbursed more than one time per day.

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

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

410-125-0580 Outpatient Therapies

(1) Physical therapy, occupational therapy, speech-language therapy, audiology and durable medical equipment are subject to the limitations in the Physical and Occupational Therapy Services, Speech-Language Pathology, Audiology and Hearing Aid Services, and Durable Medical Equipment provider guides. Physical therapy, occupational therapy, speech-language therapy, audiology and durable medical equipment providers must use one of the following ICD-9 codes in Form Locator 67 for services requiring prior authorization:

(a) V57.1-- Physical Therapy;

(b) V57.21-- Occupational Therap;

(c) V57.3-- Speech-Language Therapy;

(d) V57. 89-- Audiology;

(e) V58.9-- Durable Medical Equipment.

(2) Some Physical Therapy, Occupational Therapy, Speech-Language Therapy, and Audiology services do not require prior authorization. In these instances hospitals list the client's actual diagnosis in Form Locator 67.

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

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 Guide for information and instructions on billing for administrative exams and reports.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

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 the billing instructions 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 in Form Locator 54. (See billing instructions.) Also see Liability.

(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 which 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 which 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 OMPRO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

410-125-0641 Medicare

(1) A Medicare/Medicaid claim can automatically be sent to OMAP after it has been adjudicated by Medicare, saving the effort of a second submission, as well as ensuring a more accurate and speedier payment by OMAP. The correct Medicare payment, coinsurance, and deductible information will be automatically transmitted to OMAP by Medicare.

(2) Hard copy billings sent to Medicare can also be automatically sent to OMAP. Enter "Medicaid", "OMAP", or "Welfare" on line B or C (as appropriate) of UB-92 form locator 50 and complete form locators 52 and 53 (enter "Y" for both), 51, 58, 59, 60, and 68.

(3) Billing Medicare Claims Hard Copy: Do not bill claims to Medicaid until they have been billed to and adjudicated by Medicare.

(4) Inpatient Services Billed on Hard Copy:

(a) Medicare Part A;

(A) Enter the amount of unpaid deductible with the value code A1 in Form Locators 39-41. Do not put more than one entry in this field. Failure to correctly report the Part A deductible may result in incorrect payment;

(B) Enter the amount of the Part A payment in Form Locator 54A (Prior Payments, Payor A). Show the actual Medicare payment. Do not adjust the prior payment amount;

(C) Enter XOVR in Form Locator 11 if billing on a hard copy UB-92.

(b) Medicare Part B Only:

(A) When the client has Part B coverage only, bill the full charges to Medicaid, including any charges which were submitted to and paid by the Part B payer.

(B) Enter Type of Bill 121 in Form Locator 4;

(C) Enter the amount of the Part B payment in Form Locator 54A (Prior Payments);

(D) Do not enter XOVR in Form Locator 11.

(5) Outpatient Services Billed on Hard Copy:

(a) Medicare Part B:

(A) Enter the amount of the deductible due as value code A1 in Form Locators 39-41;

(B) Enter the amount of the co-insurance due as value code A2 in Form Locators 39-41;

(C) Enter the amount of the Medicare payment in Form Locator 54A;

(D) Enter XOVR in Form Locator 11.

(b) Medicare Patients Without Part B or With Part B but Part B does Not Cover This Service;

(c) Do not enter XOVR in Form Locator 11.

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

410-125-0680 How to Complete the UB-92 for Medicaid

(1) Provider Identification: Enter provider name, mailing address and zip code. This information is needed on HARD COPY inpatient and outpatient claims only.

(2) Patient Control Number: The patient number assigned by the hospital. This is optional. If the patient account number is entered here, OMAP will print this information (up to 12 characters) on the Remittance Advice.

(3) Type of Bill: Enter the appropriate numeric code identified in the UB-92 user's manual. The following Type of Bill Codes are accepted by OMAP:

(a) 111 -- Inpatient (use for most inpatient billings, including patients with Medicare Part A coverage only);

(b) 121 -- Inpatient (use for inpatient billings for patients with Medicare Part B coverage only);

(c) 131 -- Outpatient;

(d) 721 -- Independent End Stage Renal Dialysis Facilities;

(e) 141 -- Outpatient referenced Diagnostic Services;

(f) 831 -- Hospital-based Ambulatory Surgery;

(g) This information is required on all claims.

(4) Patient's Name: Enter the patient's name as it appears on the Medical Care Identification. This information is required on ALL claims.

(5) Date of Birth: Date of birth is entered in month, day, year format. This information may be helpful to OMAP in processing the claim, but is not required.

(6) Admission Date: Use MMDDYY format. Enter the actual admission date, even if the patient was not eligible on that date. This is required on inpatient and outpatient claims.

(7) Admission Hour: Enter the hour of admission, using numbers from 00 to 24.00, 01 = 1 A.M., 10 = 10 A.M., 13 = 1 P.M. 23 = 11 P.M., and so on. The hour is required on both inpatient and outpatient claims.

(8) Type of Admission or Service: Use the following codes: (see definitions of emergent, urgent, and non-emergent in the Hospital Services Provider Guide):

(a) 1 -- Emergent. Also use for emergency transfers between hospitals and for the combined outpatient and inpatient bills when a non-emergency outpatient procedure resulted in an emergent admission to the hospital. Use for inpatient hospital labor and delivery services for Citizen/Alien Waived Emergency Medical (CAWEM) clients. Also use to bill for outpatient emergency dental services and emergent outpatient hospital services for CAWEM clients;

(b) 2 -- Urgent;

(c) 3 -- Elective. Enter prior authorization number in Form Locator 91. See Prior Authorization section for prior authorization requirements;

(d) 4 -- Newborn.

(9) Discharge Hour: Enter the hour of discharge, using numbers from 00 to 23 (as in Form Locator 16). The hour is required on inpatient and outpatient claims.

(10) Patient Status: Enter appropriate code as follows:

(a) 01 -- Discharged to home or self care (routine discharge);

(b) 02 -- Discharged or transferred to another acute care hospital;

(c) 03 -- Discharged or transferred to skilled nursing facility (SNF);

(d) 04 -- Discharged or transferred to an intermediate care facility (ICF);

(e) 05 -- Discharged or transferred to another type of institution (not another acute care hospital);

(f) 06 -- Discharged or transferred to home under care of home health service organization;

(g) 07 -- Left against medical advice;

(h) 08 -- Discharged to home under care of Home Enteral/Parenteral Provider.

(11) 20 -- Expired: This code is required on inpatient claims only.

(12) Statement Covers Period -- Use month, day, and year numeric format. Required on both inpatient and outpatient claims:

(a) Inpatient:

(A) "From" date is the date of admission;

(B) "Through" date is the date of discharge, transfer, or expiration;

(C) Total days in this field must equal the number of accommodation days in Form Locator 46. Do not count the day of discharge when calculating the number of accommodation days. See the Revenue Codes marked with a pound (#) sign in the Hospital Services guide. These are codes which count as days.

(b) Outpatient:

(A) "From" date is the date services began;

(B) "Through" date is the last date services were provided;

(C) Patient must be eligible on all dates on which services were provided. If you bill for more than one service or for a series of services, make certain the patient was eligible during the entire time for which you are billing;

(D) This information is required on both inpatient and outpatient claims.

(13) XOVR Indicator (See General Information About Billing for additional information about Medicare billings):

(a) When billing Medicare directly and providing the Medicaid third-party payor information to Medicare, the claim will cross-over automatically; Do not put XOVR in Form Locator 27;

(b) When billing on a hard copy claim, enter XOVR as follows:

(A) Inpatient:

(i) Patient has Part A -- enter XOVR in Form Locator 11;

(ii) Patient has Part B only -- Do not enter XOVR in Form Locator 11.

(B) Outpatient:

(i) Patient has Part A only -- Do not enter XOVR in Form Locator 11;

(ii) Patient has Part B -- enter XOVR in Form Locator 11;

(iii) If the patient has Part B, but the service is not covered by Medicare, do not enter XOVR in Form Locator 11. Place an NC in the Remarks Section (Form Locator 84).

(14) Occurrence Codes And Dates of Occurrence:

(a) Enter one of the following codes and the date of occurrence if applicable. Required on both inpatient and outpatient claims when applicable;

(b) 01 (Auto accident);

(c) 04 (Employment related accident).

(15) Special Program Indicator (Condition Codes):

(a) A1 -- EPSDT/CHAP (Medicheck) if applicable;

(b) OMAP currently does not require any condition codes other than A1.

(16) HCPCS/Rates:

(a) Inpatient: No entry required;

(b) Outpatient: HCPCS codes are required for most services. Revenue codes requiring HCPCS are identified in (Revenue Code Table) of the Hospital Services Provider Guide;

(c) Enter the five digit code. Type of Service (TOS) Modifiers are no longer required on either electronically billed or hard-copy UB-92 claims;

(d) When using unlisted HCPCS codes, a description is required for pricing. Bill on hard copy and attach explanation.

(17) Revenue Codes:

(a) On each line of the claim, enter the Revenue Code which most accurately describes the service provided;

(b) Use an accommodation day Revenue Code if the patient was admitted and discharged, transferred, or expired on the same day. Revenue codes that count as accommodation days are designated by a pound sign (#) to the right of the revenue code in the Revenue Code Table in the Hospital Services Provider guide. The accommodation day Revenue Codes may be used when the patient is seen in the outpatient setting (for example, for ambulatory surgical procedures);

(c) The same Revenue Code may not appear on more than one line of an inpatient claim. You may report the same Revenue Code on multiple lines of an outpatient clam, as long as the lines are distinguishable by different

HCPCS codes in Form Locator 44 and/or different dates of service in Form Locator 45;

(d) Outpatient laboratory, diagnostic and therapeutic radiology, etc. -- Billing for technical and professional components;

(e) Bill using the appropriate Revenue Code for the technical component. If you are also billing for the professional component, use the appropriate Revenue Code from Revenue Codes 971 through 979. Bill the technical component using revenue codes 30X, 31X, 32X, 33X, 34X, 35X, 40X, 61X;

(f) Bill the professional component using Revenue codes 971, 972, 973, 974. Revenue Codes are required on all claims.

(18) Units of Service:

(a) Enter total units of service or accommodation days. Revenue Codes marked with a # sign (see Revenue Codes) count as accommodation days on inpatient claims. A Leave of Absence day(s) counts as an accommodation day;

(b) The total number of accommodation days must equal the number of days in form Locator 7. The day of discharge (the "through" date in the Form Locator 6) is not counted by OMAP's computer as a day. However, the hospital should bill charges incurred on the day of discharge;

(c) For outpatient services which are provided over a period of time, more than one service may be billed on a single claim form. The From and Through dates (Form Locator 6) must reflect the range of dates on which services were provided. The number of units of service for each Revenue Code should appear in Form Locator 46. For services which require prior authorization, such as physical therapy or occupational therapy, the units of service should not exceed the number of services authorized for that period of time. Units of Service are required on all claims after every Revenue Code.

(19) Total Charges -- Enter the total charges. At the bottom of Form Locator 42, enter Revenue Code 001. At the bottom of Form Locator 47,

enter the total charges. Do NOT include charges for non-covered services in this column. Total charges are required in all claims.

(20) Not Covered. Enter charges for not covered services in this field. Do not total these charges and do NOT include these charges in the total charges appearing in Form Locator 47.

(21) Payor Identification:

(a) Do not include OMAP copayments in this field;

(b) Identify by name up to three payor organizations from which the provider might expect some payment for the bill. This information is required;

(c) Form Locators 50 through 66 have lines marked A, B and C. Line A is for the primary payor, line B is for a secondary payor, and line C for an additional secondary payor. When billing OMAP, reserve one line for OMAP information. OMAP is secondary to all other insurances;

(d) If OMAP is the only payor enter "OMAP" or "Oregon Medicaid" on Form Locator 50 line A. If there is a primary payor other than OMAP, e.g., Medicare, enter this insurer's name on line A, and enter "OMAP" on line B (or on line C if there is more than one payor primary to OMAP).

(22) Principal Diagnosis Code is required on all claims. Enter the ICD-9-CM diagnosis code best describing the principal diagnosis (the condition established after study to be chiefly responsible for causing the hospitalization).

(23) Other Diagnosis Codes are required on all claims when applicable. Enter the ICD-9-CM diagnosis codes for up to four conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Do no enter diagnoses that relate to an earlier episode which have no bearing on the current hospital stay. "Other diagnoses" are conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring. This may affect the DRG assignment on inpatient stays.

(24) Principal Procedure required on inpatient and outpatient claims when procedures are performed. Enter the ICD-9-CM procedure code which best identifies the procedure completed. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or to treat a complication, or the procedure most related to the principal diagnosis.

(25) Other Procedure Codes And Dates are required on inpatient claims only. Enter ICD-9-CM codes for up to two other procedures performed and the date on which the procedure was performed. Hospitals are not required to code diagnostic and therapeutic procedures such as CT scans, physical, occupational, or respiratory therapy, or radiological studies.

(26) Attending Physician ID:

(a) Enter the 6-digit OMAP Provider number or the UPIN of the attending physician;

(b) If the attending physician has no OMAP Provider number, or the number is unknown, enter 999999 and the physician's name;

(c) The physician provider number is required on all inpatient claims, and required on all outpatient claims except Medicare/Medicaid "crossover" claims received by OMAP directly from Medicare.

(27) Other Physician ID: Enter the provider number of any other physician who provided care, such as a surgeon. For patients referred by a PCCM, the PCCM number appears in this field, with an R in front of the number.

(28) Remarks:

(a) Use this space for Third Party Resource (TPR) explanation codes. These are two letter identifiers (in Rule 410-120-1280);

(b) Other information which may appear in this field includes:

(A) Itemization of services provided under Revenue Code 512 (dental clinic) unless itemized on a separate attachment;

(B) A description of "unlisted" laboratory or radiology HCPCS codes which will allow manual pricing;

(C) Other information helpful in processing the claim.

(c) Claims billed electronically have a limit of 100 characters which can appear in this field. OMAP may not review information other than Third Party Resource explanation codes appearing in the Remarks section of an electronically billed UB-92. When you have important information about the claim, it is best to submit the claim hard-copy with the explanatory documentation attached.

(29) Value Codes: Units and Amounts. When billing OMAP, use these form locators to report Family Planning Percentage and Medicare Coinsurance and Deductible amounts, when applicable. Each Value Code data element consists of a 2 character alphanumeric Value Code, along with a numeric Value Code Amount:

(a) Value Code -- A1 Deductible Payor A -- When Medicare is the primary payor, identify Medicare as Payer A in Form Locator 50. Use Value Code A1 to report the Part A or Part B deductible amount (show the dollars and cents money amount of the deductible in the Amount portion of the form locator);

(b) Value Code -- A2 Coinsurance Payor A -- When Medicare is the primary payor, identify Medicare as Payor A in Form Locator 50. Use Value Code A2 to report the Part A or Part B coinsurance amount (show the dollars and cents money amount of the deductible in the Amount portion of the form locator). Note: OMAP does not require providers to report deductible and coinsurance value codes and amounts for primary insurers other than Medicare. When Medicare coverage is present, it will normally be reported as "Payor A" on the UB-92. However, in situations where Medicare is "Payor B", use Value Codes "B1" and "B2" to report Medicare coinsurance and deductible;

(c) Value Code X0 Family Planning Percent -- When family planning services are a component of services billed on the claim, OMAP requests that providers estimate the portion of the total charges related to family planning. Use Value Code "X0" and report the percentage of family

planning in the cents area of the amount field. Round to the nearest whole percentage. Report 100% as $1.00.

(30) Provider Number:

(a) Enter the 6 digit OMAP provider number on the line (A, B, or C) which corresponds to the line used to identify OMAP in Form Locator 50;

(b) The OMAP provider number is required. OMAP does not require the provider number for other payers listed in Form Locator 50.

(31) Prior Payments. Enter the actual amount of any payments received from a third party resource such as Medicare Part A, Part B, or other insurance on the line which corresponds to that payor's identification in Form Locator 50.

(32) Estimated Amount Due -- OMAP does not require the completion of this form locator, this information will not be used in processing claims.

(33) Cert -- SSN -- HIC -- ID No.:

(a) Use this field to report the patient's Medicaid Client ID number (aka "Prime Number"), using the line (A, B, C) which corresponds to OMAP's identification in Form Locator 50. Enter the number as it appears on the client's Medical Care Identification Form (aka "Medical Card");

(b) Required on all claims.

(34) Treatment Authorization Codes -- For services which have been prior-authorized by OMAP, enter the 9 digit authorization number in the line (A, B, or C) which corresponds to OMAP's identification in Form Locator 50.

(35) Service Date:

(a) Inpatient -- Not required;

(b) Outpatient -- Enter in MMDDYY format when applicable;

(c) There are two acceptable methods for billing for a series of services:

(A) You may list each date of service in form locator 45;

(B) You may bill for a series of services by indicating the number of units of service provided (form locator 46) and billing for the date range during which services were provided (form locator 6). Note: If Method (b) is used, be sure all services requiring prior authorization are billed on a single claim. If a service is later billed for the same date range, the claim will be denied as a duplicate service already paid.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-03

410-125-0700 Revenue Codes

(1) Revenue Codes may be added or deleted to conform with national billing standards and changes in Medicare.

(2) Table 125-0700

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-03

Table 125-0700 Revenue Codes

Revenue Codes may be added or deleted to conform with national billing standards and changes in Medicare.

11X ROOM AND BOARD — PRIVATE (MEDICAL OR GENERAL)
0# General Classification
1# Medical/Surgical/Gyn
2# OB
3# Pediatric
4# Psychiatric
5 Hospice (Not Covered)
6# Detoxification
7# Oncology
8# Rehab/Private
9# Other

12X ROOM AND BOARD — SEMI-PRIVATE (MEDICAL OR GENERAL)
0# General Classification
1# Medical/Surgical/Gyn
2# OB
3# Pediatric
4# Psychiatric
5 Hospice (Not Covered)
6# Detoxification
7# Oncology
8# Rehab/Semi-Private
9# Other

13X SEMI-PRIVATE — THREE AND FOUR BEDS
0# General Classification
1# Medical/Surgical/Gyn
2# OB
3# Pediatric
4# Psychiatric
5 Hospice (Not Covered)
6# Detoxification
7# Oncology
8# Rehab/3-4 Beds

9# Other

14X PRIVATE (DELUXE)
0# General Classification
1# Medical/Surgical/Gyn
2# OB
3# Pediatric
4# Psychiatric
5 Hospice (Not Covered)
6# Detoxification
7# Oncology
8# Rehab/Deluxe
9# Other

15X ROOM AND BOARD WARD (MEDICAL OR GENERAL)
0# General Classification
1# Medical/Surgical/Gyn
2# OB
3# Pediatric
4# Psychiatric
5 Hospice (Not Covered)
6# Detoxification
7# Oncology
8# Rehab/Ward
9# Other

16X OTHER ROOM AND BOARD
0# General Classification
4# Sterile Environment
7# Self Care
9# Other

17X NURSERY
0# General Classification (Nursery)
1# Newborn – Level I
2# Newborn – Level II
3# Newborn – Level III
4# Newborn – Level IV
9# Other

18X LEAVE OF ABSENCE

Bill hard-copy.
0# General Classification
1# RESERVED (Not Covered)
2# Patient Convenience (Not Covered)
3# Therapeutic Leave
4# ICF/MR — Any Reason (Not Covered)
5 Nursing Home (for hospitalization) (Not Covered)
9# Other Leave of Absence (Not Covered)

19X SUBACUTE CARE (NOT COVERED)
0 General Classification (Not Covered)
1 Subacute Care Level I (Not Covered)
2 Subacute Care Level II (Not Covered)
3 Subacute Care Level III (Not Covered)
4 Subacute Care Level IV (Not Covered)
9 Other Subacute Care (Not Covered)

20X INTENSIVE CARE
0# General Classification
1# Surgical
2# Medical
3# Pediatric
4# Psychiatric
6# Intermediate ICU
7# Burn Care
8# Trauma
9# Other Intensive Care

21X CORONARY CARE
0# General Classification
1# Myocardial Infarction
2# Pulmonary Care
3 Heart Transplant
4# Intermediate CCU
9# Other Coronary Care

22X SPECIAL CHARGES
0 General Classification (Not Covered)
1 Admission Charge (Not Covered)
2 Technical Support Charge (Not Covered)
3 U.R. Service Charge (Not Covered)

4 Late Discharge, Medically appropriate (Not Covered)
9 Other Special Charges
This Revenue Code is authorized only for Administrative Reports requested by branch office staff.

23X INCREMENTAL NURSING CHARGE RATE
0 General Classification
1 Nursery
2 OB
3 ICU
4 CCU
5 Hospice (Not Covered)
9 Other

24X ALL INCLUSIVE ANCILLARY (NOT COVERED)
0 General Classification (Not Covered)
9 Other Inclusive Ancillary (Not Covered)

25X PHARMACY
0 General Classification
1 Generic Drugs
2 Non-Generic Drugs
3 Take Home Drugs
4 Drugs Incident to Diagnostic Services
5 Drugs Incident to Radiology
6 Experimental Drugs (Not Covered)
7 Non-prescription
8 IV Solutions
9 Other Pharmacy

26X IV THERAPY
0 General Classification*
1 Infusion Pump*
2 IV Therapy/Pharmacy Services
3 IV Therapy/Drug/Supply Delivery
4 IV Therapy/Supplies
9 Other IV Therapy*

27X MEDICAL/SURGICAL SUPPLIES AND DEVICES
0 General Classification
1 Nonsterile Supplies

2 Sterile Supply
3 Take Home Supplies
4 Prosthetic/Orthotic Devices*
5 Pacemaker
6 Intraocular Lens*
7 Oxygen — Take Home
8 Other Implants
9 Other Supplies/Devices*

28X ONCOLOGY*
0 General Classification
9 Other Oncology

29X DURABLE MEDICAL EQUIPMENT (OTHER THAN RENAL)*
0 General Classification
1 Rental
2 Purchase of new durable medical equipment
3 Purchase of used durable medical equipment
4 Supplies/Drugs for DME effectiveness (Not Covered)
9 Other Equipment

Prior authorization of services is required for all outpatient services in this category (29X).

30X LABORATORY*
0 General Classification
1 Chemistry
2 Immunology
3 Renal Patient (Home)
4 Non-Routine Dialysis
5 Hematology
6 Bacteriology & Microbiology
7 Urology
9 Other Laboratory

31X LABORATORY — PATHOLOGICAL*
0 General Classification
1 Cytology
2 Histology
4 Biopsy
9 Other

32X RADIOLOGY — DIAGNOSTIC
0 General Classification*
1 Angiocardiography*
2 Arthrography
3 Arteriography*
4 Chest X-Ray*
9 Other*

33X RADIOLOGY — THERAPEUTIC*
0 General
1 Chemotherapy — Injected
2 Chemotherapy — Oral
3 Radiation Therapy
5 Chemotherapy — IV
9 Other

34X NUCLEAR MEDICINE (RADIOISOTOPES)*
0 General
1 Diagnostic
2 Therapeutic
9 Other

35X CT SCAN*
0 General
1 Head Scan
2 Body Scan
9 Other CT Scans

36X OPERATING ROOM SERVICES*
0 General Classification
1 Minor Surgery
2 Organ Transplant — other than kidney
7 Kidney Transplant
9 Other Operating Room Services

37X ANESTHESIA
0 General Classification
1 Anesthesia Incident to Radiology
2 Incident to Diagnostic Services

4 Acupuncture — (Covered only when performed by a physician or physician's employee-acupuncturist under a physician's supervision.)
9 Other Anesthesia

38X BLOOD
0 General Classification
1 Packed Red Cells
2 Whole Blood (Not Covered)
3 Plasma
4 Platelets
5 Leukocytes
6 Other Components
7 Other Derivatives (Cyroprecipitates)
9 Other Blood

39X BLOOD STORAGE AND PROCESSING
0 General Classification
1 Blood Administration
9 Other Blood Storage & Processing

40X OTHER IMAGING SERVICES*
0 General
1 Diagnostic Mammography
2 Ultrasound
3 Screening Mammography
4 Positron Emission Tomography
9 Other Imaging Services

41X RESPIRATORY SERVICES
0 General Classification*
2 Inhalation Services
3 Hyperbaric Oxygen Therapy
9 Other Respiratory Services

42X PHYSICAL THERAPY*
0 General Classification
1 Visit Charge
2 Hourly Charge
3 Group Rate
4 Evaluation or Reevaluation

9 Other Physical Therapy

Prior authorization of services is required for outpatient physical therapy services, unless Medicare part B is the primary payer. Evaluations do not require prior authorization.

43X OCCUPATIONAL THERAPY*

0 General Classification
1 Visit Charge
2 Hourly Charge
3 Group Rate
4 Evaluation or Reevaluation
9 Other Occupational Therapy

Prior authorization of services is required for outpatient occupational therapy services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.

44X SPEECH-LANGUAGE PATHOLOGY*

0 General Classification
1 Visit Charge
2 Hourly Charge
3 Group Rate
4 Evaluation or Reevaluation
9 Other Speech-Language Pathology

Prior authorization of services is required for outpatient speech-language services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.

45X EMERGENCY ROOM

0 General Classification*
1 EMTALA Emergency Medical Screening Services
2 ER Beyond EMTALA Screening
6 Urgent Care
9 Other Emergency Room*

46X PULMONARY FUNCTION*

0 General Classification
9 Other Pulmonary Function

47X AUDIOLOGY*

0 General Classification
1 Diagnostic
2 Treatment
9 Other Audiology

Prior authorization of services is required for outpatient audiology services, unless Medicare Part B is the primary payer. Evaluations (471) do not require prior authorization.

48X CARDIOLOGY
0 General Classification*
1 Cardiac Cath Lab*
2 Stress Test*
3 Echocardiology
9 Other Cardiology*

49X AMBULATORY SURGICAL CARE*
0 General Classification
9 Other Ambulatory Surgical Care

50X OUTPATIENT SERVICES
0 General Classification
9 Other Outpatient Services

51X CLINIC
0 General Classification*
1 Chronic Pain Center (Not Covered)
2 Dental Clinic - (Prior authorization of services required for non-emergency services.)
3 Psychiatric Clinic
4 OB/GYN Clinic
5 Pediatric Clinic
6 Urgent Care Clinic
7 Family Practice Clinic
9 Other Clinic

52X FREE-STANDING CLINIC
0 General Classification (Not Covered)
1 Rural Health — Clinic
2 Rural Health — Home (Not Covered)
3 Family Practice

6 Urgent Care Clinic
9 Other — (Not Covered)

53X OSTEOPATHIC SERVICES
0 General Classification
1 Osteopathic Therapy
9 Other Osteopathic Services

54X AMBULANCE
0 General Classification (Not Covered)
1 Supplies (Not Covered)
2 Medical Transport

542 (Medical Transport) - This Revenue Code must be used to bill for medical transportation costs incurred by an admitting hospital in the transport of patients to another facility or provider **if:**

- The other facility or provider provides a service not available at the admitting hospital; and
- The patient is returned to the admitting hospital within 24 hours.

No other transportation services may be billed on the UB-92.

3 Heart Mobile (Not Covered)
4 Oxygen (Not Covered)
5 Air Ambulance (Not Covered)
6 Neonatal Ambulance Service (Not Covered)
7 Ambulance Pharmacy (Not Covered)
8 Telephonic EKG (Not Covered)
9 Other Ambulance (Not Covered)

55X SKILLED NURSING (NOT COVERED)
0 General Classification (Not Covered)
1 Visit Charge (Not Covered)
2 Hourly Charge (Not Covered)
9 Other Skilled Nursing (Not Covered)

56X MEDICAL SOCIAL SERVICES
0 General Classification (Not covered in outpatient setting)
1 Visit Charge (Not covered in outpatient setting)

2 Hourly Charge (Not covered in outpatient setting)
9 Other Medical Social Services*

Covered in outpatient setting for Maternity Case Management services only. Use OMAP unique codes in Field 50 to bill these services.

57X HOME HEALTH AIDE (HOME HEALTH) (NOT COVERED)
0 General Classification (Not Covered)
1 Visit Charge (Not Covered)
2 Hourly Charge (Not Covered)
9 Other Home Health Aide (Not Covered)

58X OTHER VISITS (HOME HEALTH) (NOT COVERED)
0 General Classification (Not Covered)
1 Visit Charge (Not Covered)
2 Hourly Charge (Not Covered)
9 Other Home Health Visits (Not Covered)

59X UNITS OF SERVICE (HOME HEALTH) (NOT COVERED)
0 General Classification (Not Covered)
9 Home Health Other Units (Not Covered)

60X OXYGEN — HOME HEALTH (NOT COVERED)
0 General Classification (Not Covered)
1 Oxygen-State/Equip/Supply or contents (Not Covered)
2 Oxygen-State/Equip/Supply Under 1 LPM (Not Covered)
3 Oxygen-State/Equip/Supply Over 4 LPM (Not Covered)
4 Oxygen – Portable Add-On (Not Covered)

61X MAGNETIC RESONANCE IMAGING (MRI)*
0 General Classification
1 Brain (including brain stem)
2 Spinal Cord (including spine)
9 Other

62X MEDICAL/SURGICAL SUPPLIES — EXTENSION OF 27X
1 Supplies Incident to Radiology
2 Supplies Incident to Other Diagnostic Services
3 Surgical Dressing
4 Investigational Device (Not Covered)

63X DRUGS REQUIRING SPECIFIC IDENTIFICATION

0 General Classification (Not Covered)
1 Single source drug
2 Multiple source drug
3 Restrictive prescription
4 Epoetin, under 10,000 units per administration
5 Epoetin, 10,000 units or more per administration
6 Drugs requiring detail coding*
7 Self-administrable Drugs

64X HOME IV THERAPY SERVICES (NOT COVERED)
0 General Classification (Not Covered)
1 Nonroutine Nursing (Not Covered)
2 IV Site Care, Central Line (Not Covered)
3 IV StartChange Peripheral Line (Not Covered)
4 Nonroutine Nursing, Peripheral Line (Not Covered)
5 Training Patient/Caregiver, Central Line (Not Covered)
6 Training Disabled Patient, Central Line (Not Covered)
7 Training Patient/Caregiver, Peripheral Line (Not Covered)
8 Training Disabled Patient, Peripheral Line (Not Covered)
9 Other IV Therapy Services (Not Covered)

65X HOSPICE SERVICES (NOT COVERED)
0 General Classification (Not Covered)
1 Routine Home Care (Not Covered)
2 Continuous Home Care (Not Covered)
3 Reserved (Not Covered)
4 Reserved (Not Covered)
5 Inpatient Respite Care (Not Covered)
6 General Inpatient Care (Non-Respite) (Not Covered)
7 Physician Services (Not Covered)
9 Other Hospice (Not Covered)

66X RESPITE CARE (HOME HEALTH) (NOT COVERED)
0 General (Not Covered)
1 Hourly Charge/Skilled Nursing (Not Covered)
2 Hourly Charge/Home Health (Not Covered)

67X OUTPATIENT SPECIAL RESIDENCE CHARGES (NOT COVERED)
0 General (Not Covered)

1 Hospital-Based (Not Covered)
2 Contracted (Not Covered)
9 Other (Not Covered)

68X NOT ASSIGNED (NOT COVERED)

69X NOT ASSIGNED (NOT COVERED)

70X CAST ROOM*
0 General Classification
9 Other Cast Room

71X RECOVERY ROOM
0 General Classification
9 Other Recovery Room

72X LABOR ROOM/DELIVERY
0 General Classification
1 Labor
2 Delivery
3 Circumcision
4# Birthing Center
9 Other Labor Room/Delivery

73X EKG/ECG (ELECTROCARDIOGRAM)*
0 General Classification
1 Holter Monitor
2 Telemetry
9 Other EKG/ECG

74X EEG (ELECTROENCEPHALOGRAM)*
0 General Classification
9 Other EEG

75X GASTROINTESTINAL SERVICES*
0 General Classification
9 Other Gastrointestinal

76X TREATMENT OR OBSERVATION ROOM*
0 General Classification
1 Treatment Room
2 Observation Room

9 Other Treatment Room

77X PREVENTIVE CARE SERVICES
0 General
1 Vaccine Care Services*
9 Other

78X TELEMEDICINE – MEDICARE DEMONSTRATION PROJECT (NOT COVERED)
0 General Classification (Not Covered)
9 Other Telemedicine (Not Covered)

79X LITHOTRIPSY*
0 General Classification
9 Other

80X INPATIENT RENAL DIALYSIS
0 General Classification
1 Inpatient Hemodialysis
2 Inpatient Peritoneal (non-CAPD)
3 Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
4 Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
9 Other Inpatient Dialysis

81X ORGAN ACQUISITION*
0 General Classification
1 Living Donor
2 Cadaver Donor
3 Unknown Donor
4 Unsuccessful Organ Bank Donor Search Charge
9 Other Organ Acquisition

82X HEMODIALYSIS — OUTPATIENT OR HOME
0 General Classification
1 Hemodialysis/Composite or Other Rate
2 Home Supplies
3 Home Equipment
4 Maintenance/100%
5 Support Services
9 Other Outpatient Hemodialysis

83X PERITONEAL DIALYSIS — OUTPATIENT OR HOME

0 General Classification
1 Peritoneal/Composite or Other Rate
2 Home Supplies
3 Home Equipment
4 Maintenance/100%
5 Support Services
9 Other Outpatient Peritoneal Dialysis

84X CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) — OUTPATIENT OR HOME
0 General Classification
1 CAPD/Composite or Other Rate
2 Home Supplies
3 Home Equipment
4 Maintenance/100%
5 Support Services
9 Other Outpatient CAPD

85X CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD) — OUTPATIENT OR HOME
0 General Classification
1 CCPD/Composite or Other Rate
2 Home Supplies
3 Home Equipment
4 Maintenance/100%
5 Support Services
9 Other Outpatient CCPD

86X RESERVED FOR DIALYSIS (NATIONAL ASSIGNMENT)

87X RESERVED FOR DIALYSIS (NATIONAL ASSIGNMENT)

88X MISCELLANEOUS DIALYSIS
0 General Classification
1 Ultrafiltration
2 Home Dialysis Aid Visit (Not Covered)
9 Misc. Dialysis Other

89X OTHER DONOR BANK (RESERVED FOR NATIONAL ASSIGNMENT)*

90X PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS

0 General Classification (Not Covered)
1 Electroconvulsive Therapy
2 Milieu Therapy (Not Covered)
3 Play Therapy (Not Covered)
4 Activity Therapy (Not Covered)
9 Other*
(Somatotherapy services and psychiatric or psychological evaluations are the only services billable under this Revenue Code.)

NOTE: Somatotherapy services and psychiatric or psychological evaluations are the only services billable under Revenue Codes 919 and 961.

91X PSYCHIATRIC/PSYCHOLOGICAL SERVICES
0 General Classification (Not Covered)
1 Rehabilitation (Not Covered)
2 Partial Hospitalization Less Intensive (Not Covered)
3 Partial Hospitalization Intensive (Not Covered)
4 Individual Therapy (Not Covered)
5 Group Therapy (Not Covered)
6 Family Therapy (Not Covered)
7 Biofeedback (Not Covered)
8 Testing*
9 Other*

92X OTHER DIAGNOSTIC SERVICES*
0 General Classification
1 Peripheral Vascular Lab
2 Electromyelogram
3 Pap Smear
4 Allergy Test
5 Pregnancy Test
9 Other Diagnostic Services

93X NOT ASSIGNED (NOT COVERED)

94X OTHER THERAPEUTIC SERVICES
0 General Classification*
1 Recreational Therapy (Not Covered)
2 Education/Training*
3 Cardiac Rehabilitation*
4 Drug Rehabilitation (Not Covered)
5 Alcohol Rehabilitation (Not Covered)

6 Routine Complex Equipment
7 Ancillary Complex Equipment*
9 Other Therapeutic Services*

95X NOT ASSIGNED (NOT COVERED)

96X PROFESSIONAL FEES*
0 General Classification
1 Psychiatric
2 Ophthalmology
3 Anesthesiologist (MD)
4 Anesthetist (CRNA)
9 Other Professional Fees

97X PROFESSIONAL FEES (continued)
1 Laboratory*
2 Radiology — Diagnostic*
3 Radiology — Therapeutic*
4 Radiology — Nuclear Medicine*
5 Operating Room
6 Respiratory Therapy
7 Physical Therapy (Outpatient services require prior authorization)
8 Occupational therapy (Outpatient services require prior authorization)
9 Speech Pathology (Outpatient services require prior authorization)

98X PROFESSIONAL FEES*
1 Emergency Room
2 Outpatient Services
3 Clinic
4 Medical Social Services (Covered in inpatient setting only)
5 EKG
6 EEG
7 Hospital Visit
8 Consultation
9 Private Duty Nurse (Not Covered)

99X PATIENT CONVENIENCE ITEMS
0 General Classification (Not Covered)
1 Cafeteria/Guest Tray (Not Covered)
2 Private Linen Service (Not Covered)

3 Telephone/Telegraph (Not Covered)
4 TV/Radio (Not Covered)
5 Nonpatient Room Rentals (Not Covered)
6 Late Discharge Charge (Not Covered)
7 Admissions Kits (Covered)
8 Beauty Shop/Barber (Not Covered)
9 Other Patient Convenience Items (Not Covered)

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-82. 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 -- (OMAP), Salem, OR 97309.

(3) How to complete an adjustment request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) Attach needed documentation;

(c) Mail the Adjustment Request to the address on the form;

(d) Enter the 13-digit Internal Control Number (ICN). This number can be found on the RA;

(e) Enter the client's eight-digit OMAP identification number in this space. This number can be found on the RA, or on the client' Medical Card;

(f) Enter the client's name as it is on the Medical Card;

(g) Enter your six-digit OMAP provider number;

(h) Enter the name of the hospital;

(i) Enter the date which is printed at the top of your RA;

(j) Description -- Possible areas you might want to change are listed. Only check those you want to change;

(k) Type of Service -- Use to correct the HCPCS/CPT-4 modifier for laboratory and other outpatient procedures;

(l) Quantity/Unit -- Use to correct the number of services you are billing;

(m) Billed Amount -- The amount you billed OMAP;

(n) Procedure Code -- Use to correct the procedure code for laboratory and other outpatient procedures;

(o) Revenue Code -- Use to correct Revenue Codes;

(p) Insurance Payment/Patient Liability -- The payments from other sources;

(q) Other -- Use to correct ICD-9-CM Codes appearing on the RA. Use if none of the above address your problems;

(r) Line # -- List the line number from the original claim (UB-82) being adjusted;

(s) Service Date -- Enter the date the service was performed;

(t) Wrong Information -- Enter the incorrect information submitted on the original claim in this column;

(u) Right Information -- Enter the corrected information in this column;

(v) Remarks -- List any other information that is related to this Adjustment Request. The patient's account number may be entered here;

(w) Provider's Signature -- The provider or other authorized personnel must sign;

(x) Date -- Enter the date this form was completed.

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

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

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

Type A and Type B hospitals must submit the following information to the Office of Medical Assistance Programs:

(1) 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

(2) 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.

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

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 Oregon Medical Professional Review Organization (OMPRO) to conduct post payment review of admissions. OMPRO may request records from a hospital or may request access to records while at the hospital. OMPRO has the same right to medical information as OMAP.

(3) The hospital has 30 days to provide OMAP or OMPRO 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

4-1-2004

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 OMPRO. 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 OMPRO determines that a hospital admission was not medically necessary, 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 contractor (OMPRO), 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 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 determined not medically necessary and/or appropriate by OMPRO acting on behalf of Medicare.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

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) A readmission to the same hospital if OMPRO determines that the readmission was the result of a premature discharge;

(c) Services which were billed but not provided;

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

(e) OMAP non-covered services;

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

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

(2) Payment to a physician 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).

(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, actions deemed appropriate by OMPRO, or sanctions established under State Law 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
10-1-00

410-125-2040 Provider Appeals -- Administrative Review

(1) The Administrative Review process may be used by providers to request review of Office of Medical Assistance Programs (OMAP) decisions affecting the provider. See General Rules.

(2) A requests for an Administrative Review must be submitted in writing to the Medicaid Administrator, 203 Public Service Building, Salem, OR 97310.

(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
10-1-91

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. 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
10-1-91

410-125-2080 Administrative Errors

(1) If a hospital has been given incorrect information by Office of Medical Assistance Programs, or by Adult and Family Services/Children's Services Division/Senior and Disabled Services Division/Mental Health and Developmental Disability Services Division 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, Salem, OR 97310

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