Authorization Page

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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Adopted on	
Upon filing.	
Effective date	

RULE CAPTION

Rules related to client appeals/hearings, provider requirements related to billing clients for non-covered services

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:

410-141-0262,410-141-0263,410-141-0265,410-141-0420,410-141-3260,410-141-3263,410-141-3395,410-141-3420

REPEAL:

RENUMBER:

AMEND & RENUMBER:

10/31/13

Stat. Auth.:: ORS 413.042,414.065,414.615,414.625,414.635,414.651

Other Auth.::

10/31/13

Stats. Implemented:: ORS 414.065,414.610-685 OL 2011, Ch 602 Sec. 13,14,16,17,62,64(2),65, HB 3650

RULE SUMMARY

Rules are amended to require providers to review with and have OHP clients sign a new OHP Client Agreement to Pay for Health Services form, DMAP 3165, or facsimile containing the elements of the form, before providing and charging clients for non-covered services. Rules are further revised to allow for use of a new Medical Assistance Service Denial Appeal and Hearing Request form, or Division approved facsimile, to be used in place of the MSC 443 and DMAP 3030 forms; change the standard for client failure to meet timely filing/actions from 'circumstances beyond the control of the client' to 'good cause;' state that providers shall not bill a client or submit a client billing to a Collection Agency for any amount owed by the CCO for which the client is not liable; clarify current policy and for housekeeping purposes.

Rhonda Busek	Rhonda Busek	10-31-18
Authorized Signer	Printed Name	Date

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410-141-0262 Prepaid Health Plan Appeal Procedures

(1) A Division of Medical Assistance Programs (Division) Member or their representative that disagrees with a Notice of Action may file a Prepaid Health Plan (PHP) level appeal or request a Division administrative hearing. Division members may not be required to go through a PHP level appeal in order to request a Division administrative hearing.

(2) The PHP must have a system in place for Division member which includes an appeal process when a Division member has requested a Division administrative hearing. For purposes of this rule, an appeal includes a request to the PHP for review of an Action upon notification from the Division.

(3) An appeal must be filed with the PHP no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263.

(4) If the Division member initiates an appeal directly with the PHP, it shall be documented in writing by the PHP and handled as an appeal consistent with this rule. The Division member or Division member's representative may file an appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed appeal.

(5) Each PHP must adopt written policies and procedures for handling appeals that, at a minimum, meet the following requirements:

(a) Give Division members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal or administrative hearings request. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Tele Typewriter (TTY)/ Telecommunications Devices for the Deaf (TTD) and interpreter capacity;

(b) Address how the PHP will accept, process and respond to such appeals, including how the PHP will acknowledge receipt of each appeal;

(c) Ensuring that Division members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an appeal and an administrative hearing request and how to do so;

(d) Ensuring that each appeal is transmitted timely to staff having authority to act on it;

(e) Ensuring that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensuring that the individuals who make decisions on appeals are individuals:

(A) Who were not involved in any previous level of review or decision making; and

(B) Who are health care professionals who have the appropriate clinical expertise in treating the Division member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues:

(g) Include a requirement for appeals to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(6) The PHP shall assure Division members that appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the appeal have a right to use this information for purposes of resolving the appeal and for purposes of maintaining the log required in OAR 410-141-0266 and for health oversight purposes by Division, without a signed release from the Division member. The administrative hearing regarding the appeal without a signed release from the Division member, pursuant to 410-120-1360(4);

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the appeal to other individuals. Before any information related to the appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the appeal file.

(7) The process for appeals must:

(a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the Division member or Division member's representative requests expedited resolution;

(b) Provide the Division member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the Division member or the Division member's representative of the limited time available in the case of an expedited resolution);

(c) Provide the Division member and/or the Division member's representative an opportunity, before and during the appeals process, to examine the Division member's file, including medical records and any other documents or records to be considered during the appeals process; and

(d) Include as parties to the appeal the Division member, the Division member's representative, or the legal representative of a deceased Division member's estate.

(8) The PHP must resolve each appeal and provide a client notice of the appeal resolution as expeditiously as the Division member's health condition requires and within the time frames in this section:

(a) For the standard resolution of appeals and client notices to the Division member or Division member's representative, the PHP shall resolve the appeal and provide a client notice no later than 16 calendar days from the day the PHP receives the appeal.

(b) When the PHP has granted a request for expedited resolution of an appeal, the PHP shall resolve the appeal and provide a client notice no later than 3 working days after the PHP receives the appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(c) In accordance with 42 CFR 438.408, the PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:

(A) The Division member or Division members representative requests the extension; or

(B) The PHP shows (to the satisfaction of the Division's Hearings Unit upon its request) that there is need for additional information and how the delay is in the Division member's interest;

(d) If the PHP extends the timeframes, it must, for any extension not requested by the Division member, give the Division member or Division member's representative a written notice of the reason for the delay.

(9) For all appeals, the PHP must provide written Notice of Appeal Resolution to the Division member or their representative. If the PHP knows that there is a representative, the PHP must send a copy of the Notice to the representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.

(10) The written Notice of Appeal Resolution must be on a Division approved form and include the following:

(a) The results of the resolution process and the date it was completed; and

(b) For appeals not resolved wholly in favor of the Division member, the notice must also include the following information:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the PHP from the Division as part of an administrative hearings process, the right to request a Division Administrative Hearing, and how to do so, which includes attaching the appropriate forms as outlined in 410-141-0263;

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(D) That the Division member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.

(11) Unless the appeal was referred to the PHP as part of an administrative hearing process, a Division member may request a Division administrative hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution. The parties to the Division administrative hearing include the PHP as well as the Division member and/or Division member's representative, or the Representative of the deceased Division member's estate.

(12) Each PHP shall establish and maintain an expedited review process for appeals, consistent with OAR 410-141-0265.

(13) Each PHP shall maintain records of appeals, enter appeals and their resolution into a log, and address the appeals in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(14) Continuation of benefits pending appeal:

(a) As used in this section, "timely" filing means filing on or before the later of the following:

(A) Within 10 calendar days of the PHP mailing the Notice of Action; or

(B) The intended effective date of the PHP's proposed Action:

(b) The PHP must continue the Division member's benefits if:

(A) The Division member or Division member's representative files the appeal or administrative hearing request timely;

(B) The appeal or administrative hearing request involves the termination, suspension, or reduction of a previously authorized course of treatment;

(C) The services were ordered by an authorized provider;

(D) The original period covered by the original authorization has not expired; and

(E) The Division member or representative requests extension of benefits:

(c) Continuation of benefits pending administrative hearing — If, at the Division member's request, the PHP continues or reinstates the Division member's benefits while the appeal or administrative hearing is pending , the benefits must be continued pending administrative hearing pursuant to OAR 410-141-0264.

(15) If the final resolution of the appeal or administrative hearing is adverse to the Division member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the Division member while the appeal or administrative hearing was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

(16) If the PHP or a Division administrative hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the Division member's health condition requires.

(17) If the PHP or the Division administrative hearing decision reverses a decision to deny authorization of services, and the Division member received the disputed services while the appeal was pending, the PHP or the Division must pay for the services in accordance with the Division policy and regulations.

(18) If the appeal was referred to the PHP from the Division as part of an administrative hearing process, the PHP must immediately (within two business days) transmit the Notice of Appeal Resolution and the complete record of the appeal to the Division Hearings Unit.

(19) If the appeal was made directly by the Division member or Representative, and if the Notice of Appeal Resolution was not favorable to the Division member, the PHP must: Retain a complete record of the appeal for not less than 45 days so that, if an administrative hearing is requested, the record can be submitted to the Division's Hearings Unit within two business days of the Division's request.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

410-141-0263 Notice of Action by a Prepaid Health Plan

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) When a Prepaid Health Plan (PHP) (or authorized practitioner (see definition) acting on behalf of the PHP) takes or intends to take any "action," including but not limited to denials or limiting prior authorizations of a requested service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other action, the PHP (or authorized practitioner acting on behalf of the PHP) shall mail a written client (see definition) Notice of Action in accordance with section (2) of this rule to the Division member (see definition) within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be on a Division approved form and must be used for all denials of a requested service(s), reductions, discontinuations or terminations of previously authorized services, denials of claims payment, or other action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the Division member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) The Division member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service;

(G) Effective date of the action, if different from the date of the NOA;

(H) Whether the PHP considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(b) The action the PHP or its participating provider (see definition) has taken or intends to take;

(c) Reasons for the action, with enough specificity to clearly explain the actual reason for the denial, including but not limited to the following reasons:

(A) The item requires pre-authorization and it was not pre-authorized;

(B) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(C) The person was not a Division member at the time of the service or is not a Division member at the time of a requested service; and

(D) The provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan rules);

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section, in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The Division member's right to file an appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The Division member's right to request a Division administrative hearing and how to exercise that right. A copy of the following forms must be attached to the Notice of Action:

(A) Hearing Request form, (DHS 443), and the Notice of Hearing Rights, (DMAP 3030), or

(B) The Medical Assistance Service Denial Appeal and Hearing Request form, DMAP 1234, or approved facsimile.

(g) The circumstances under which expedited appeal resolution is available and how to request it;

(h) The Division member's right to have benefits continue pending resolution of the appeal, how to request that benefit(s) be continued, and the circumstances under which the Division member may be required to pay the costs of these services; and

(i) The telephone number to contact the PHP for additional information.

(3) The PHP or practitioner acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension, or reduction of previously authorized OHP covered services (see definition), the following time frames apply:

(A) The notice must be mailed at least 10 calendar days before the date of action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP (or authorized practitioner acting on behalf of the PHP) may mail a notice not later than the date of action if:

(i) The PHP or practitioner receives a clear written statement signed by the Division member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The Division member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The Division member's whereabouts are unknown and the post office returns PHP or practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another State, territory, or commonwealth has accepted the Division member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the Division member's PCP or PCD; or

(vi) The date of action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5)(ii), related to discharges or transfers and long-term care facilities:

(C) The PHP may shorten the period of advance notice to 5 calendar days before the date of the action if the PHP has facts indicating that an action should be taken because of probable fraud by the Division member. Whenever possible, these facts should be verified through secondary sources:

(b) For denial of payment, at the time of any action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the

Division member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the Division member or the provider requests the extension; or if the PHP justifies (to the Division upon request) a need for additional information and how the extension is in the Division member's interest;

(B) If the PHP extends the timeframe, in accordance with subsection (A) of this section, it must give the Division member written notice of the reason for the decision to extend the timeframe and inform the Division member of their right to file a grievance if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the Division member's health condition requires and no later than the date the extension expires;

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire;

(e) For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

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

Stat. Auth.: ORS 409.110,413.042 & 414.065
Stats. Implemented: ORS 414.065

410-141-0265 Request for Expedited Appeal or Expedited Administrative Hearing

(1) Each PHP shall establish and maintain an expedited review process for appeals, when the PHP determines (upon request from the Division of Medical Assistance Programs (Division) member) or the provider indicates (in making the request on a Division member's behalf or supporting the DMAP member's request) that taking the time for a standard resolution could seriously jeopardize the Division member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Division member's appeal.

(3) If the PHP provides an expedited appeal, but denies the services or items requested in the expedited appeal, the PHP shall inform the Division member of the right to request an expedited Administrative Hearing and send the member a Division approved Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-0263 with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on appeal, it must:

(a) Transfer the appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A Division member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the Division member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to the Division's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. The Division's Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether the Division member is entitled to an expedited Administrative Hearing.

(7) If the Division's Medical Director denies a request for expedited Administrative Hearing, the Division must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

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

Stat. Auth.: ORS 409.110 & 413.042
Stats. Implemented: ORS 414.065

410-141-0420 Managed Care Prepaid Health Plan Billing and Payment under the Oregon Health Plan

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) Providers must submit all billings for Oregon Health Plan (OHP) clients to Prepaid Health Plans (PHPs) and to the Division within four (4) months of the date of service, subject to other applicable Division billing rules. A billing that was submitted within (4) months of the date of service, but that was denied, may be resubmitted within (6) months of the date of service. Providers must submit billings to PHPs within the four (4) month time frame except in the following cases:

(a) Pregnancy;

(b) Eligibility issues such as retroactive deletions or retroactive enrollments;

(c) Medicare is the primary payer;

(d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of provider to certify the Division member's (see definition) eligibility); or

(e) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payer of last resort and is not considered an alternative liability or TPL.

(2) Providers must be enrolled with the Division to be eligible for Division fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), must be approved by the Local Mental Health Authority (LMHA) and the Addictions and Mental Health (AMH) Division before enrollment with the Division or to be eligible for PHP payment for services. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260, Provider Enrollment.

(3) Providers, including mental health providers (see definition), must be enrolled with the Division either as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the servicing provider is not excluded per federal and State standard as defined in OAR 407-120-0300.

(4) Providers shall verify, before rendering services, which Division member is eligible for the Medical Assistance Program on the date of service using the Division tools and optionally the PHP's tools, as applicable and that the service to be rendered is covered under the Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorizations from the appropriate payer before rendering services. Before providing a non-covered service, the provider must complete, and have the member sign, a DMAP 3165, or facsimile, as described in OAR 410-120-1280.

(5) PHPs are responsible for payment of all capitated services. Such services should be billed directly to the PHP, unless the PHP or the Division specifies otherwise. PHPs may require providers to obtain preauthorization to deliver certain capitated services.

(6) Payment by the PHP to participating providers for capitated services is a matter between the PHP and the participating provider, except as follows:

(a) Pre-authorizations:

(A) PHPs shall have written procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:

(i) Date stamping pre-authorization requests when received;

(ii) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;

(iii) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;

(iv)The specific number of days following receipt of the additional information that a redetermination must be made;

(v) Providing services after office hours and on weekends that require preauthorization;

(vi) Sending notice of the decision with appeal rights to the Division member when the determination is made to deny the requested service as specified in 410-141-0263.

(B) PHPs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHP shall notify providers of such determination within 2 working days of receipt of the request;

(C) For expedited prior authorization requests in which the provider indicates, or the PHP determines, that following the standard timeframe could seriously jeopardize the Division member's life or health or ability to attain, maintain, or regain maximum function:

(i) The PHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request for service;

(ii) The PHP may extend the three working days time period by up to 14 calendar days if the Division member requests an extension, or if the PHP justifies to the Division a need for additional information and how the extension is in the member's interest.

(D) For all other preauthorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within 14 calendar days of receipt of the request. PHPs must make reasonable efforts to obtain the necessary information during that 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information, if the PHP justifies (to the Division upon request) the need for additional information and how the delay is in the interest of the Division member. If the PHP exends the timeframe, it shall give the Division member written notice of the reason for the extension, as outlined in OAR 410-141-0263. The PHP shall make a determination as the Division member's health condition requires, but no later than the expiration of the extension.

(b) Claims payment:

(A) PHPs shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for:

(i) Date stamping claims when received;

(ii) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(iii) The specific number of days allowed for follow up of pended claims to obtain additional information;

(iv) The specific number of days following receipt of additional information that a determination must be made; and

(v) Sending notice of the decision with appeal rights to the Division member when the determination is made to deny the claim.

(B) PHPs shall pay or deny at least 90% of valid claims within 45 calendar days of receipt and at least 99% of valid claims within 60 calendars days of receipt. PHPs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(C) PHPs shall provide written notification of PHP determinations when such determinations result in a denial of payment for services, as outlined in 410-141-0263.

(D) PHPs shall not require providers to delay billing to the PHP;

(E) PHPs shall not require Medicare be billed as the primary insurer for services or items not covered by Medicare, nor require non-Medicare approved providers to bill Medicare;

(F) PHPs shall not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the Division member's clinical record;

(G) PHPs shall not delay nor deny payments because a co-payment was not collected at the time of service.

(c) FCHPs, PCOs, and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the Division member receives within the PHP, for authorized referral care, and for urgent care services or emergency services the Division member receives from non-participating providers (see definition). FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care Division members receive from non-participating providers;

(d) FCHPs and PCOs shall pay transportation, meals and lodging costs for the Division member and any required attendant for out-of-state services (as defined in General Rules, chapter 410, division 120) that the FCHP and PCO has arranged and authorized when those services are available within the state, unless otherwise approved by the Division;

(e) PHPs shall be responsible for payment of covered services (see definition) provided by a non-participating provider which was not pre-authorized if the following conditions exist:

(A) It can be verified that the participating provider (see definition) ordered or directed the covered services to be delivered by a non-participating provider; and

(B) The covered service was delivered in good faith without the pre-authorization; and

(C) It was a covered service that would have been pre-authorized with a participating provider if the PHP's referral protocols had been followed;

(D) The PHP shall be responsible for payment to non-participating providers (providers enrolled with the Division that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.

(7) Other services:

(a) Division members enrolled with PHPs may receive certain services on a Division FFS basis. Such services are referred to as non-capitated services (see definition);

(b) Certain services must be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though such services are then paid by the Division on a Division FFS basis. Before providing services, providers should verify a Division member's eligibility via the web portal or AVR. For

some mental health services, providers will need to contact the CMHP directly. In addition, the provider may call the PHP to obtain information about coverage for a particular service or pre-authorization requirements;

(c) Services authorized by the PHP or CMHP are subject to the rules and limitations of the appropriate Division administrative rules and supplemental information, including rates and billing instructions;

(d) Providers shall bill the Division directly for non-capitated services in accordance with billing instructions contained in the Division administrative rules and supplemental information;

(e) The Division shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions and Division administrative rules and supplemental information;

(f) The Division shall not pay a provider for provision of services for which a PHP has received a capitation payment unless otherwise provided for in OAR 410-141-0120;

(g) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of the Division, AMH, nor a PHP except as provided for in Division administrative rules and supplemental information (e.g., capitated services that are not included in the nursing facility all-inclusive rate);

(h) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the FCHP or PCO would make for the same service(s) furnished by a provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(8) Coverage of services through the Oregon Health Plan Benefit Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

(9) OHP clients who are enrolled with a PCM receive services on a FFS basis:

(a) PCMs are paid a per client-per month payment to provide Primary Care Management Services, in accordance with OAR 410-141-0410, Primary Care Manager Medical Management;

(b) PCMs provide primary care access, and management services for preventive services, primary care services, referrals for specialty services, limited inpatient hospital services and outpatient hospital services. The Division payment for these PCM managed services is contingent upon PCCM authorization;

(c) All PCM managed services are covered services that shall be billed directly to the Division in accordance with billing instructions contained in the Division administrative rules and supplemental information;

(d) The Division shall pay at the Division FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

(10) All OHP clients who are enrolled with a PCO receive inpatient hospital services on a Division FFS basis:

(a) May receive services directly from any appropriately enrolled Division provider;

(b) All services shall be billed directly to the Division in accordance with FFS billing instructions contained in the Division administrative rules and supplemental information;

(c) The Division shall pay at the Division FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

(11) OHP clients who are not enrolled with a PHP receive services on a Division FFS basis:

(a) Services may be received directly from any appropriate enrolled Division provider;

(b) All services shall be billed directly to the Division in accordance with billing instructions contained in the Division administrative rules and supplemental information;

(c) The Division shall pay at the Division FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division administrative rules and supplemental information.

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

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065

410-141-3260 Grievance System: Grievances, Appeals and Contested Case Hearings

(1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.

(2) The CCO must establish and have a Division approved process and written procedures, for the following:

(a) Member rights to appeal and request a CCO's review of an action;

(b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and

(c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

(d) An explanation of how CCOs shall accept, process, and respond to appeals, hearing requests, and grievances;

(e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.

(3) Upon receipt of a grievance or appeal, the CCO must:

(a) Acknowledge receipt to the member;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues;

(d) Ensure that staff making decisions on the grievance or appeal are:

(A) Not involved in any previous level of review or decision-making; and

(B) Health care professionals, as defined in OAR 410-120-0000, with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.

(4) The CCO must analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.

(5) CCOs must keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment, or CCO health care operations, are defined in 45 CFR 164.501.

(6) The following pertains to release of a member's information:

(a) The CCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log.

(b) If the CCO needs to communicate with other individuals or entities, not listed in subsection (a), to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:

(a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services;

(c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process;

(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

(9) In all CCO administrative offices and in those physical, behavioral, and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) Appeal forms;

(c) Hearing request form, (DHS 443) and Notice of Hearing Rights (DMAP 3030); or

(d) The Medical Assistance Service Programs Denial Appeal and Hearing Request form (DMAP 1234), or approved facsimile.

(10) A member's provider:

(a) Acting on behalf of and with written consent of the member, may file an appeal;

(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests, and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the CCO's review, resolution, or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

(a) Life, health, mental health or dental health; or

(b) Ability to attain, maintain or regain maximum function.

(16) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a)To be entitled to continuing benefits, the member must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay for good cause, as defined in OAR 137-002-0528, is not counted;

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits, no later than ten days following the date of the notice of appeal resolution;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 414.685

410-141-3263 Notice of Action

(1) A CCO must provide a member with a notice of action when the CCO's decision about a health service constitutes an action. The notice of action must:

(a) Be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the action and requesting a hearing;

(b) Comply with the Authority's formatting and readability standards;

(c) The notice must include but is not limited to the following:

(A) Date of the notice;

(B) CCO's name and telephone number;

(C) Name of the member's PCP, PCD, or behavioral health professional, as applicable;

(D) Member's name and member ID number;

(E) Service requested and whether the CCO is denying, terminating, suspending or reducing a service or payment;

(F) Date of the service or date the member requested the service;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the action if different from the date of the notice;

(I) Whether the CCO considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(J) Clearly and thoroughly explain specific reasons for the action and a reference to the specific sections of the statutes and rules pertaining to each reason;

(K) Member's right to file an appeal with the CCO or request a contested case hearing;

(L) An explanation of circumstances under which the member may request expedited resolution of an appeal, and how to request one; and

(M) A statement that the member has the right to request to receive the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the CCO's action;

(d) The Notice of Action must be on a Division approved form.

(2) The CCO must include the appropriate forms based on the Division approved Notice of Action, as outlined in OAR 410-141-3260, to the notice.

(3) For actions affecting previously authorized services, the CCO must mail the notice at least 10 calendar days before the date of action with the exception of circumstances described in section (4) of this rule.

(4) The CCO may mail the notice no later than the date of action if:

(a) The CCO or provider has information confirming the death of the member;

(b) The member sends the CCO a signed statement stating the member no longer wants the service;

(c) The CCO can verify that the member is in an institution where the member is no longer eligible for OHP services;

(d) The CCO is unaware of the member's whereabouts; the post office returns the mail indicating no forwarding address; and the Authority or Department of Human Services has no other address;

(e) The CCO verifies another state, territory, or commonwealth has accepted the member for Medicaid services;

(f) The member's PCP, PCD, or behavioral health professional has prescribed a change in the level of health services; or

(g) The date of action shall occur in less than 10 calendar days when the CCO:

(A) Has facts indicating probable fraud by the member, and the CCO has certified those facts, if possible, through a secondary resource; or

(B) Denies payment for a claim.

(5) For actions affecting services not previously authorized, the CCO must send the notice as expeditiously as the member's health condition requires but no later than 14 calendar days following the date of receipt of the request for service.

(6) For actions affecting services not previously authorized and for which the CCO grants expedited review, the CCO must send the notice as expeditiously as the member's health condition requires but no later than three business days after receipt of the request for service.

(7) In accordance with 42 CFR 438.408, the CCO may extend the timeframes from (5) above by up to 14 calendar days, if:

(a) The Division member or Division member's representative requests the extension; or

(b) The CCO shows (to the satisfaction of the Division's Hearings Unit upon it request) that there is need for additional information and how the delay is in the Division member's interest.

(8) If the CCO extends the timeframes, it must, for any extension not requested by the Division member, give the Division member and Division member's representative, a written notice of the reason for the delay.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650

410-141-3395 Member Protection Provisions

(1) In the event of a finding of impairment by OHA or of a termination of certification as a CCO or of the CCO contract, members of the CCO shall be offered disenrollment from the CCO and enrollment in accordance with OHA rule.

(2) For the purpose of this section only, and only in the event of a finding of impairment by OHA or of a termination of certification or of the CCO contract, any covered health care service furnished within the state by a provider to a member of a CCO shall be considered to have been furnished pursuant to a contract between the provider and the CCO with whom the member was enrolled when the services were furnished.

(3) Each contract between a CCO and a provider of health services shall provide that if the CCO fails to pay for covered health services as set forth in the contract, the member is not liable to the provider for any amounts owed by the CCO.

(4) If the contract between the contracting provider and the CCO has not been reduced to writing or fails to contain the provisions required by this rule, the member is not liable to the contracting provider for any amounts owed by the CCO.

(5) No contracting provider or agent, trustee or assignee of the contracting provider shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule and under 410-120-1280.

(6) Nothing in this section impairs the right of a provider to charge, collect from, and attempt to collect from or maintain a civil action against a member for any of the following:

(a) Deductible, copayment or coinsurance amounts;

(b) Health services not covered by the CCO, if a valid DMAP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

(c) Health services rendered after the termination of the contract between the CCO and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract. Before providing a non-covered service, the provider must complete a DMAP 3165, or facsimile, as described in OAR 410-120-1280.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650

410-141-3420 Billing and Payment

(1) Subject to other applicable Division billing rules, providers must submit all billings for CCO members following the timeframes in (a) and (b) below:

(a) Submit billings within 12 months of the date of service in the following cases:

(A) Member pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the CCO is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the CCO (which does not include failure of provider to certify the member's eligibility); or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payer of last resort and is not considered an alternative liability or TPL.

(b) Submit bills within four months of the date of service for all other cases.

(2) Providers must be enrolled with the Authority's Division of Medical Assistance Programs to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), must be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) Division before enrollment with the Authority or to be eligible for CCO payment for services. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260 (Provider Enrollment).

(3) Providers, including mental health providers, must be enrolled with the Authority as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted.

(4) Providers shall verify, before providing services, that the member is eligible for coordinated care services on the date of service. Providers shall use the Authority tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider must complete a DMAP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(5) CCOs shall pay for all covered coordinated care services. These services must be billed directly to the CCO, unless the CCO or the Authority specifies otherwise. CCOs may require providers to obtain preauthorization to deliver certain coordinated care services.

(6) Payment by the CCO to participating providers for coordinated care services is a matter between the CCO and the participating provider, except as follows:

(a) CCOs shall have procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:

(A) Date stamping pre-authorization requests when received;

(B) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;

(C) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;

(D)The specific number of days following receipt of the additional information that a redetermination must be made;

(E) Providing services after office hours and on weekends that require preauthorization;

(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) CCOs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO must provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within 2 working days of receipt of the request;

(c) For expedited prior authorization requests in which the provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The CCO may extend the three working day time period no more than 14 calendar days if the member requests an extension, or if the CCO justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(d) For all other preauthorization requests, CCOs shall notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request, as outlined in 410-141-3263, CCOs must make reasonable efforts to obtain the necessary information during the 14-day period. However, the CCO may use an additional 14 days to obtain follow-up information, if the CCO justifies (to the Authority upon request) the need for additional information and how the delay is in the interest of the member. The CCO shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

(7) CCOs shall have written procedures for processing payment claims submitted from any source. The procedures shall specify time frames for:

(a) Date stamping claims when received;

(b) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(c) The specific number of days allowed for follow up of pended claims to obtain additional information;

(d) The specific number of days following receipt of additional information that a determination must be made; and

(e) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim;

(f) CCOs shall pay or deny at least 90% of valid claims within 45 calendar days of receipt and at least 99% of valid claims within 60 calendars days of receipt. CCOs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(g) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services as outlined in 410-141-3263;

(h) CCOs may not require providers to delay billing to the CCO;

(i) CCOs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare, or require non-Medicare approved providers to bill Medicare;

(j) CCOs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(k) CCOs may not delay or deny payments because a co-payment was not collected at the time of service.

(8) CCOs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO, for authorized referral care, and urgent care services or emergency services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) CCOs shall pay transportation, meals and lodging costs for the member and any required attendant for services that the CCO has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) CCOs shall pay for covered services provided by a non-participating provider which was not pre-authorized if the following conditions exist:

(a) It can be verified that the participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The covered service was delivered in good faith without the pre-authorization; and

(c) It was a covered service that would have been pre-authorized with a participating provider if the CCO's referral procedures had been followed;

(d) The CCO shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the CCO) for covered services that are subject to reimbursement from the CCO, in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals;

(e) CCOs shall reimburse hospitals for services provided on or after January 1, 2012 using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods which incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services; and alternative payment methodologies, including but not limited to pay-for-performance, bundled payments and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. CCO shall attest annually to the Authority, in a manner to be prescribed, to CCO's compliance with these requirements.

(11) Members may receive certain services on a Fee for Service (FFS) basis:

(a) Certain services must be authorized by the CCO or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers must verify a member's eligibility using the web portal or AVR;

(b) Services authorized by the CCO or CMHP are subject to the rules and limitations of the appropriate Authority administrative rules and supplemental information, including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions;

(e) The Authority may not pay a provider for provision of services for which a CCO has received a CCO payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of the Authority or a CCO except as provided in Authority administrative rules and supplemental information (e.g., coordinated care services that are not included in the nursing facility all-inclusive rate);

(g) CCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the CCO would pay for the same service furnished by a provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(12) Coverage of services through the Oregon Health Plan Benefit Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650