



# Oregon

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**To:** Service Providers *Joan M. Kapowich*  
**From:** Joan M. Kapowich, Manager  
Program and Policy Section, OMAP  
**Subject:** OHP Provider Guide Revision #2

**Effective Date:** February 1, 2003

The Office of Medical Assistance Programs (OMAP) is revising the *Oregon Health Plan (OHP)* provider guide, effective February 1, 2003. \*\*Until the guide revision is posted to the website, please reference the attached Administrative rules and note the following summary of changes:

**Summary of changes:**

- In response to Legislative mandate, OMAP restructured the Oregon Health Plan (OHP) benefit packages. Rules 410-141-0000, 410-141-0080, 410-141-0420 and 410-141-0500 are amended to reflect the changes.

Read these rules carefully as they will affect your payments.

At this time the guide has not been revised. The above rules will be incorporated into the next revision of this guide.

If you have a billing question, contact a Provider Services Representative, toll-free at 1-800-336-6016 or (503) 378-3697 (direct). Additional information for providers is available at OMAP's website: [www.omap.hr.state.or.us/providerinfo/](http://www.omap.hr.state.or.us/providerinfo/)

#### 410-141-0000 Definitions

(1) Administrative Hearing -- A hearing related to a denial, reduction, or termination of benefits which is held when requested by the OHP Client or OMAP Member. A hearing may also be held when requested by an OHP Client or OMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(2) Advance Directive -- A form that allows a person to have another person make health care decisions when he/she cannot make the decision and tells a doctor that the person does not want any life sustaining help if he/she is near death.

(3) Aged -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of age.

(4) Americans with Disabilities Act (ADA) -- Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(5) Alternative Care Settings -- Sites or groups of practitioners which provide care to OMAP Members under contract with the PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, outpatient surgicenters.

(6) Ancillary Services -- Those medical services under the Oregon Health Plan not identified in the definition of a Condition/Treatment Pair under the OHP Benefit Package, but Medically Appropriate to support a service covered under the OHP benefit package. A list of ancillary services and limitations is identified in OAR 410-141-0520, Prioritized List of Health Services, or specified in the Ancillary Services Criteria Guide.

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

(8) Blind -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(9) Capitated Services -- Those services that a PHP or Primary Care Case Manager agrees to provide for a Capitation Payment under an OMAP Oregon Health Plan contract.

(10) Capitation Payment -- Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP. Monthly prepayment to a Primary Care Case Manager to provide

Primary Care Case Management Services for an OHP Client who is enrolled with the PCCM. Payment is made on a per client, per month basis.

(11) Centers for Medicare and Medicaid Services (CMS); formerly HCFA. The federal agency under the Department of Health and Human Services, responsible for approving the waiver request to operate the Oregon Health Plan Medicaid Demonstration Project.

(12) Chemical Dependency Services — Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the “Chemical Dependency Placement, Continued Stay, and Discharge Criteria.”

(13) Chemical Dependency Organization (CDO) -- a Prepaid Health Plan that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the Oregon Health Plan. All chemical dependency services covered under the Oregon Health Plan are covered as Capitated Services by the CDO.

(14) Chemical Dependency Services -- Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

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

(16) Children Receiving CAFor OYA Services -- Individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of Children, Adults and Families Services, Department of Human Services or Oregon Youth Authority who are in placement outside of their homes.

(17) Clinical Record -- The Clinical Record includes the medical, dental, or mental health records of an OHP Client or OMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the ENCC, Complaint and Disenrollment for Cause records which may reside in the PHP's administrative offices.

(18) Comfort Care -- The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to

make it possible for an individual with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice Guide), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for disabled infants with life-threatening conditions that are not covered under Condition/Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 - Patient Self-Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(19) Community Mental Health Program (CMHP) -- The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an inter-governmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(20) Comorbid Condition -- A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient. See OAR 410-141-0480(7).

(21) Complaint -- An OMAP Member's, a PCCM Member's, or a Member's Representative's clear expression of dissatisfaction with the Prepaid Health Plan or the Primary Care Case Manager which addresses issues that are part of the Prepaid Health Plan or Primary Care Case Manager contractual responsibility. The expression may be in whatever form of communication or language that is used by the Member or the Member's Representative but must state the reason for the dissatisfaction.

(22) Community Standard -- Typical expectations for access to the health care delivery system in the OMAP Member's or PCCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, OMAP requires that the health care delivery system available to OMAP Members in Prepaid Health Plans and to PCCM Members with Primary Care Case Managers take into consideration the Community Standard and be adequate to meet the needs of OMAP and PCCM Members.

(23) Condition/Treatment Pair -- Diagnoses described in the Interna-

tional Classification of Diseases Clinical Modifications, 9th edition (ICD-9 CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or Mental Health and Developmental Services Division Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

(24) Continuing Treatment Benefit -- A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to the OHP Benefit Package of Covered Services and that treatment is not covered under the OHP Benefit Package of Covered Services.

(25) Copayment -- The portion of a Covered Service that an OMAP Member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.

(26) Contract -- The contract between the State of Oregon, acting by and through its Department of Human Services, Office of Medical Assistance Programs (OMAP) and a Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), or a Chemical Dependency Organization (CDO) for the provision of Covered Services to OMAP Members for a Capitation Payment. Previously referred to as a Service Agreement.

(27) Dentally Appropriate -- Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the Oregon Health Plan Member or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to an OMAP Member.

(28) \$500 Dental Benefit Calculation -- Based on the OMAP Standard composite dental fee schedule, less copayments and TPR for Covered Services.

(29) \$500 Dental Benefit Period -- Two periods from January 1 through June 30 and July 1 through December 31, regardless of the time frames of an

eligibility period. The \$500 Benefit does not carry from one Benefit Period to another.

(30) Dental Care Organization (DCO)-- A Prepaid Health Plan that provides and coordinates capitated dental services. All dental services covered under the Oregon Health Plan are covered as Capitated Services by the DCO; no dental services are paid by OMAP on a fee-for-service basis for Oregon Health Plan Clients enrolled with a DCO provider.

(31) Dental Case Management Services -- Services provided to ensure that OMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the Member plus the development and implementation of a plan to ensure that OMAP Members obtain Capitated Services.

(32) Dental Emergency Services -- Dental services may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(33) Dental Practitioner -- A practitioner who provides dental services to OMAP Members under an agreement with a DCO, or is a Fee-For-Service Health Care Practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(34) Department of Human Services (DHS) -- The Department comprised of seven divisions and three major program offices: Administrative Services; Community Human Services; Continuous System Improvement; Finance and Policy Analysis; Children, Adults and Families; Health Services and Seniors and People with Disabilities; and within Health Services, the programs include the Office of Medical Assistance Programs and Mental Health and Addiction Services, as well as the Office of Vocational Rehabilitation Services within Community Human Services.

(35) Diagnostic Services -- Those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(36) Disabled -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of Medical Assistance because of a disability.

(37) Disenrollment -- The act of discharging an Oregon Health Plan Client from a Prepaid Health Plan's or Primary Care Case Manager's responsibility. After the effective date of Disenrollment an Oregon Health Plan Client is no longer required to obtain Capitated Services from the Prepaid Health Plan or Primary Care Case Manager, nor be referred by the Prepaid Health

Plan for Medical Case Managed Services or by the Primary Care Case Manager for PCCM Case Managed Services.

(38) Dual Eligible -- OHP Clients who are receiving both Medicaid and Medicare benefits.

(39) Emergency Services -- The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of both the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. If an emergency medical condition is found to exist, emergency medical services necessary to stabilize the condition must be provided. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

(40) Enrollment -- Oregon Health Plan Clients, subject to OAR 410-141-0060 - Oregon Health Plan Managed Care Enrollment Requirements, become OMAP Members of a Prepaid Health Plan or PCCM Members of a Primary Care Case Manager that contracts with OMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the OMAP Member must obtain or be referred by the PHP for all Capitated Services and referred by the PHP for all Medical Case Managed Services subsequent to the effective date of Enrollment. An Oregon Health Plan Client's Enrollment with a Primary Care Case Manager indicates that the PCCM Member must obtain or be referred by the Primary Care Case Manager for preventive and primary care and referred by the Primary Care Case Manager for all PCCM Case Managed Services subsequent to the effective date of Enrollment.

(41) Enrollment Area -- Client enrollment is based on the client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system which indicates to the DHS worker which Plan(s) are in the area.

(42) Enrollment Year -- A twelve month period beginning the first day of the month of Enrollment of the Oregon Health Plan Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of Oregon Health Plan Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(43) End Stage Renal Disease (ESRD) -- End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.

(44) Exceptional Needs Care Coordination (ENCC) -- A specialized case management service provided by Fully Capitated Health Plans to OMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405, Oregon Health Plan Prepaid Health Plan Exceptional Needs Care Coordination (ENCC). ENCC includes:

(a) Early identification of those Aged, Blind or Disabled OMAP Members that have disabilities or complex medical needs;

(b) Assistance to ensure timely access to providers and Capitated Services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of Capitated Services and discharge planning; and

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(45) Family Health Insurance Assistance Program (FHIAP) -- A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the FPL. FHIAP is funded with federal and states funds through either Title XIX, XXI or both.

(46) Family Planning Services -- Services for clients of childbearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(47) Fee-for-Service Health Care Providers -- Health care providers who bill for each service provided and are paid by OMAP for services as described in OMAP provider guides. Certain services are covered but are not provided by Prepaid Health Plans or by Primary Care Case Managers. The client may seek such services from an appropriate Fee-For-Service provider. Primary Care Case Managers provide primary care services on a fee-for-service basis and might also refer PCCM Members to specialists and other providers for fee-for-service care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP Clients in these areas will receive all services from Fee-For-Service providers.

(48) Free-Standing Mental Health Organization (MHO) -- The single

MHO in each county that provides only mental health services and is not affiliated with a Fully Capitated Health Plan for that service area. In most cases this "carve-out" MHO is a county Community Mental Health Program or a consortium of Community Mental Health Programs, but may be a private behavioral health care company.

(49) Fully Capitated Health Plan (FCHP) -- Prepaid Health Plans that contract with OMAP to provide capitated services under the Oregon Health Plan. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(50) Health Care Professionals -- Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Licensed Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of OMAP members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

(51) Health Insurance Portability and Accountability Act (HIPAA) of 1996 -- HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(52) Health Management Unit (HMU) -- The OMAP unit responsible for adjustments to enrollments, retroactive disenrollment and enrollment of newborns.

(53) Health Plan New/Noncategorical Client (HPN) -- A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an Oregon Health Plan Client.

(54) Health Services Commission -- An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.

(55) Hospice Services -- A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice

Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

(56) Hospital Hold -- A hospital hold is a process that allows a 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. OHP clients shall be exempted from mandatory enrollment with an FCHP, if clients become eligible through a hospital hold process and are placed in the Adults/Couples category.

(57) Line Items -- Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the Oregon Health Plan Medicaid Demonstration Project.

(58) Local and Regional Allied Agencies -- Local and Regional Allied Agencies include the following: local Mental Health Authority; Community Mental Health Programs; local offices of DHS agencies( CAFS, SPD); Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

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

(60) Medical Assistance Program -- A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by identified Divisions and the Office of Medical Assistance Programs (OMAP), of the Department of Human Services. Coordination of the Medical Assistance Program is the responsibility of the Office of Medical Assistance Programs.

(61) Medical Care Identification -- The preferred term for what is commonly called the "medical card". It is a letter-sized document issued monthly to Medical Assistance Program clients to verify their eligibility for services and enrollment in PHPs.

(62) Medical Case Management Services -- Medical Case Management Services are services provided to ensure that OMAP Members obtain health care services necessary to maintain physical and emotional development and

health. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.

(63) Medically Appropriate -- Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an Oregon Health Plan Client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of Medical services or medical supplies that can be safely provided to an OMAP Member or PCCM Member in the PHP's or Primary Care Case Manager's judgment.

(64) Medicare -- The federal health insurance program for the aged and disabled administered by the Health Care Financing Administration under Title XVIII of the Social Security Act.

(65) Medicare HMO -- A capitated health plan that meets specific referral guidelines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(66) Mental Health Assessment -- The determination of an OMAP Member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a Member's mental status, psychosocial history and current problems through interview, observation and testing.

(67) Mental Health Case Management -- Services provided to OMAP Members who require assistance to ensure access to benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the OMAP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring OMAP Members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.

(68) Mental Health Organization (MHO) -- A Prepaid Health Plan under

contract with the Office of Mental Health and Addiction Services that provides mental health services as capitated services under the Oregon Health Plan. MHOs can be Fully Capitated Health Plans, community mental health programs or private behavioral organizations or combinations thereof.

(69) Non-Capitated Services -- Those OHP-covered services which are paid for on a fee-for-service basis and for which a capitation payment has not been made to a PHP.

(70) Non Covered Services -- Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the Oregon Health Plan. Non-Covered Services for the Oregon Health Plan are identified in:

(a) OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual provider guides.

(71) Non-Participating Provider -- A provider who does not have a contractual relationship with the Prepaid Health Plan, i.e. is not on their panel of providers.

(72) Office of Medical Assistance Programs (OMAP) -- The Office of the Department of Human Services responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and the Children's Health Insurance Program (CHIP). OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays OMAP providers.

(73) Office of Mental Health and Addiction Services (OMHAS); formerly MHDDSD and OADAP-- The Department of Human Services agency responsible for the administration of the state's mental health and developmental disability services and which coordinates policy and programs for the state's chemical dependency prevention, intervention, and treatment services.

(74) OMAP Member -- An Oregon Health Plan Client enrolled with a Prepaid Health Plan.

(75) Ombudsman Services -- Services provided by DHS to Aged, Blind and Disabled Oregon Health Plan Clients by DHS Ombudsman Staff who may serve as the Oregon Health Plan Client's advocate whenever the Oregon Health Plan Client, Representative, a physician or other medical personnel, or other personal advocate serving the Oregon Health Plan Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the Oregon Health Plan. Ombudsman Services include response to individual complaints about access to care, quality

of care or limits to care; and response to complaints about Oregon Health Plan systems.

(76) Oregon Health Plan (OHP) -- The Medicaid demonstration project which expands Medicaid eligibility to eligible Oregon Health Plan Clients. The Oregon Health Plan relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(77) Oregon Health Plan (OHP) Plus Benefit Package -- A benefit package available to eligible Oregon Health Plan clients as described in OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-120-0520, Prioritized List of Health Services.

(78) Oregon Health Plan (OHP) Standard Benefit Package -- A benefit package available to eligible Oregon Health Plan clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-141-0520, Prioritized List of Health Services.

(79) Oregon Health Plan Client -- An individual found eligible by a DHS Division to receive services under the Oregon Health Plan. The individual might or might not be enrolled in a Prepaid Health Plan or with a Primary Care Case Manager. The OHP categories eligible to enroll in Prepaid Health Plans are defined as follows:

(a) Aid to Families with Dependent Children (AFDC) are categorical eligibles with income under current eligibility rules;

(b) Children's Health Insurance Program (CHIP) - children under one year of age who have income under 170% FPL and do not meet one of the other eligibility classifications;

(c) PLM (Poverty Level Medical) Adults under 100% Federal Poverty Level (FPL) are OHP recipients who are pregnant women with income under 100% of FPL;

(d) PLM Adults over 100% FPL are OHP recipients who are pregnant women with income between 100% and 170% of the FPL;

(e) PLM children under one year of age have family income under 133% FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 170% FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 170% FPL and do not meet one of the other eligibility

classifications;

(h) OHP Adults and Couples are OHP recipients aged 19 or over and not Medicare eligible, with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP Families are OHP recipients, aged 19 or over and not Medicare eligible, with income below 100% of FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) GA (General Assistance) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) AB/AD (Assistance to Blind and Disabled) with Medicare Eligibles are OHP recipients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare Eligibles are OHP recipients without Medicare with income under current eligibility rules;

(m) OAA (Old Age Assistance) with Medicare Eligibles are OHP recipients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP recipients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP recipients who are children with medical eligibility determined by Children, Adults and Families or the Oregon Youth Authority receiving OHP under ORS 414.025 (2) (f), (l), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of the Children, Adults and Families or the Oregon Youth Authority who are in placement outside of their homes.

(80) Oregon Youth Authority -- The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(81) Participating Provider -- An individual, facility, corporate entity, or other organization which supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PHP.

(82) PCCM Case Managed Services -- PCCM Case Managed Services include the following: Preventive Services, primary care services and specialty

services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, Community Mental Health Programs, Mental Health Organizations; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(83) PCCM Member -- An Oregon Health Plan Client enrolled with a Primary Care Case Manager.

(84) Post Hospital Extended Care Benefit -- A 20 day benefit for non-Medicare OMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(85) Practitioner -- A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(86) Prepaid Health Plan (PHP) -- A managed health, dental, or mental health care organization that contracts with OMAP and/or ONHAS on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), or Chemical Dependency Organizations (CDOs).

(87) Preventive Services -- Those services as defined under Expanded Definition of Preventive Services for Oregon Health Plan clients in OAR 410-141-0480, The Oregon Health Plan Benefit Package of Covered Services, and OAR 410-141-0520, Prioritized List of Health Services.

(88) Primary Care Case Management Services -- Primary Care Case Management Services are services provided to ensure PCCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Case Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(89) Primary Care Case Manager (PCCM) -- A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Case Management Services as defined in rule to PCCM Members. Primary Care Case Managers may also be hospital primary care clinics, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCCM provides Pri-

mary Care Case Management Services to PCCM Members for a Capitation Payment. The PCCM provides preventive and primary care services on a fee-for-service basis.

(90) Primary Care Provider (PCP) -- A practitioner who has responsibility for supervising, coordinating initial and primary care within their scope of practice for OMAP Members, Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically or dental appropriate care.

(91) Prioritized List of Health Services -- The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

(92) Proof of Indian Heritage -- Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service - services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(93) Provider -- An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(94) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(95) Representative -- A person who can make Oregon Health Plan related decisions for Oregon Health Plan Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the Oregon Health Plan Client's health care representative, a court-appointed guardian, a spouse, or other family

member as designated by the Oregon Health Plan client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(96) Rural -- A geographic area 10 or more map miles from a population center of 30,000 people or less.

(97) Seniors and People with Disabilities (SPD) -- The Division responsible for providing three types of services:

(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;

(b) Cash assistance grants for persons with long-term disabilities through General Assistance and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(98) Service Area -- The geographic area in which the PHP has identified in their Agreement to provide services under the Oregon Health Plan.

(99) Terminal Illness -- An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(100) Triage -- Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(101) Urban -- A geographic area less than 10 map miles from a population center of 30,000 people or more.

(102) Urgent Care Services -- Covered services required in order to prevent a serious deterioration of an OMAP Member's or PCCM Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services.

(103) Valid Claim -- An invoice received by the PHP for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

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

(c) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

(104) Valid Pre-Authorization -- A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the

provider of the service or from a third party; and

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

Statutory Authority: ORS 409

Statutes Implemented: 414.065

410-141-0080

## Oregon Health Plan Disenrollment from Prepaid Health Plans

### (1) Client Requests for Disenrollment:

(a) All Oregon Health Plan (OHP) Client-initiated requests for Disenrollment from Prepaid Health Plans (PHP) must be initiated by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and OAR 461-110-0720, respectively. For OHP Clients who are not able to request Disenrollment on their own, the request may be initiated by the OHP Client's Representative;

(b) Primary person or Representative requests for Disenrollment shall be honored:

(A) After six months of OMAP Member's Enrollment without cause. The effective date of Disenrollment shall be the end of the month following the request for Disenrollment;

(B) Whenever OMAP Member eligibility is redetermined by Department of Human Services (DHS) and the Primary Person requests Disenrollment without cause. The effective date of Disenrollment shall be the end of the month following the date that the OMAP Member's eligibility is redetermined by DHS;

(C) OMAP Members who disenroll from a Medicare HMO shall also be Disenrolled from the corresponding PHP. The effective date of Disenrollment shall be the same date that their Medicare Health Maintenance Organization (HMO) disenrollment is effective;

(D) OMAP Members who are receiving Medicare and who are enrolled in a PHP that has a corresponding Medicare HMO may Disenroll from the PHP at any time if they also request disenrollment from the Medicare HMO. The effective date of Disenrollment from the PHP shall be the end of the month following the date of request for Disenrollment;

(E) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for Disenrollment. The determination shall be made within ten working days;

(ii) Examples of sufficient cause include but are not limited to:

(I) The OMAP Member moves out of the PHP's service area;

(II) It would be detrimental to the OMAP Member's health to remain enrolled in the PHP;

(III) The OMAP Member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program or urban clinic and the Fee-For-Service delivery system;

(IV) Continuity of care that is not in conflict with any section of 410-141-0060 or 410-141-0080.

(F) If the following conditions are met:

(i) The Member is in the third trimester of her pregnancy and has just been determined eligible for OHP, or has just been redetermined eligible and was not enrolled in a Fully Capitated Health Plan (FCHP) within the past 3 months; and

(ii) The new FCHP the Member is enrolled with does not contract with the Member's current OB provider and the Member wishes to continue obtaining maternity services from that Non-Participating provider; and

(iii) The request to change plans or return to fee-for-service is made prior to the date of delivery.

(c) In addition to the Disenrollment constraints listed in (b), above, OMAP Member Disenrollment requests are subject to the following requirements:

(A) The OMAP Member shall join another PHP, unless the OMAP Member resides in a service area where Enrollment is voluntary, or the OMAP Member meets the exemptions to enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory service area is the plan from which the OMAP Member wishes to disenroll, the OMAP Member may not disenroll without cause;

(C) The effective date of Disenrollment shall be the end of the month in which Disenrollment was requested unless retroactive Disenrollment is approved by OMAP.

(2) Prepaid Health Plan requests for Disenrollment:

(a) Causes for Disenrollment:

(A) OMAP may Disenroll OMAP Members for cause when requested by the PHP subject to ADA requirements and approval by Centers for Medicare and Medicaid Services, formerly Health Care Financing Administration (HCFA), if a Medicare Member disenrolled in a PHP's Medicare HMO. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of appointments are to be established by provider or PHP. The number must be the same as for commercial members or patients. The provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the Member in receiving services. This rule does not apply to Medicare Members who are enrolled in a PHP's Medicare HMO;

(ii) Member's behavior is disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the provider's ability to furnish services to either the Member or other members;

(iii) Member commits or threatens an act of physical violence directed at a medical provider or property, the provider's staff, or other patients, or the PHP's staff;

(iv) Member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal

acts committed in any provider's or Prepaid Health Plan's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF), formerly Adult & Family Services, Fraud Unit as appropriate;

(v) Members who have been exempted from mandatory enrollment with a FCHP, due to the members eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060 (4) (b) (C).

(vi) Member fails to pay copayment(s) for Covered Services as described in OAR 410-121-0153.

(B) OMAP Members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

(ii) Because of an adverse change in the Member's health;

(iii) Because of the Member's utilization of services, either excessive or lack thereof;

(iv) Because the Member requests a hearing;

(v) Because the Member has been diagnosed with end-stage renal disease;

(vi) Because the Member exercises his/her option to make decisions regarding his/her medical care with which the plan disagrees.

(C) Requests by the PHP for Disenrollment of specific OMAP Members shall be submitted in writing to their PHP Coordinator for approval. The PHP must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below must be followed prior to requesting disenrollment of an OMAP Member (except in cases of threats or acts of physical violence, and fraudulent or illegal acts). In cases of threats or acts of physical violence, OMAP will consider an oral request for Disenrollment, with written documentation to follow: In cases of fraudulent or illegal acts, the PHP must submit written documentation for review by the PHP Coordinators:

(i) There shall be notification from the provider to the PHP at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the PHP. Such notification shall be documented in Member's clinical record. The PHP shall conduct provider education regarding the need for early intervention and the services they can offer the provider;

(ii) The PHP shall contact the Member either verbally or in writing, depending on the severity of the problem, to develop an agreement regarding the issue(s). If contact is verbal, it shall be documented in the Member's record. The PHP shall inform the Member that his/her continued behavior may

result in disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other intervention's in a serious effort to resolve the problem;

(iv) The PHP shall contact the Member's DHS caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of provider, caseworker, Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain a release of information to providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the Member's record;

(vi) If a Primary Care Provider (PCP) terminates the patient/provider relationship, the PHP shall attempt to locate another PCP on their panel who will accept the Member as their patient. If needed, the PHP shall obtain a release of information in order to share the information necessary for a new provider to evaluate if they can treat the Member. All terminations of provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP's or PCP's policies for commercial members.

(D) If the problem persists, the PHP may request disenrollment of the Member by submitting a written request to disenroll the Member to the plans' PHP Coordinator, with a copy to the Member's caseworker. Documentation with the request shall include the following:

(i) The reason the PHP is requesting disenrollment; a summary of the PHP's efforts to resolve the problem and other options attempted before requesting disenrollment;

(ii) Documentation should be objective, with as much specific details and direct quotes as possible when problems involve disruptive, unruly, abusive or threatening behaviors;

(iii) Where appropriate, background documentation including a description of Member's age, diagnosis, mental status (including their level of understanding of the problem and situation), functional status (their level of independence) and social support system;

(iv) Where appropriate, separate statements from PCPs, caseworker and other agencies, providers or individuals involved;

(v) If reason for the request is related to the OMAP Member's substance abuse treatment, the PHP shall notify the OHP Coordinator in the Office of Alcohol and Drug Abuse Services;

(vi) If Member is disabled, the following documentation shall also be submitted as appropriate:

(I) A written assessment of the relationship of the behavior to the

disability including: current medical knowledge or best available objective evidence to ascertain the nature, duration and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(II) An interdisciplinary team review that includes a mental health professional and/or behavioral specialists to assess the behavior, its history, and previous history of efforts to manage behavior;

(III) If warranted, a clinical assessment that the behavior will not respond to reasonable clinical or social interventions;

(IV) Documentation of any accommodations that have been attempted;

(V) Any additional information or assessments requested by the PHP Coordinators.

(E) Requests will be reviewed according to the following process:

(i) If there is sufficient documentation, the request will be evaluated by a team of PHP Coordinators who may request additional information from Ombudsman, mental health or other agencies as needed;

(ii) If there is not sufficient documentation, the PHP Coordinator will notify the PHP what additional documentation is required before the request can be considered;

(iii) The PHP Coordinators will review the request and notify the PHP of the decision within ten working days of receipt. Written decisions, including reasons for denials, will be sent to the PHP within 15 working days from receipt of request;

(iv) If the request is approved, the Disenrollment date is 30 days after the date of approval, except as provided in (F) and (G) below. The PHP must send the Member a letter within 14 days after the request was approved, with a copy to the Member's DHS caseworker and OMAP's Health Management Unit (HMU), except in cases where the Member is also enrolled in a PHP's Medicare HMO. The letter must give the disenrollment date, the reason for disenrollment, and the notice of Member's right to an Administrative Hearing;

(v) In cases where the Member is also enrolled in a PHP's Medicare HMO, the letter shall be sent after the approval by CMS and the date of disenrollment shall be the date of disenrollment as approved by CMS. If CMS does not approve the disenrollment, the Member shall not be disenrolled from the PHP's OHP Plan;

(vi) If Member requests a hearing, the Member will continue to be Disenrolled until a hearing decision reversing that disenrollment has been mailed to the Member and the PHP;

(vii) The PHP Coordinators will determine when enrollment in another PHP or with a PCCM is appropriate. PHP Coordinator will contact Member's DHS caseworker to arrange enrollment;

(viii) When the disenrollment date has been determined, HMU sends a letter to the Member with a copy to the Member's DHS caseworker and the PHP. The letter shall inform Member of the requirement to be enrolled in another PHP.

(F) If the PHP Coordinators approve a PHP's request for Disenrollment because the OMAP Member threatens or commits an act of physical violence directed at a medical provider, the provider's staff, or other patients, the following procedures shall apply:

(i) OMAP shall inform the Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) All OMAP Members in the OMAP Member's benefit group, as defined in OAR 461-110-0720, may be Disenrolled if the PHP requests;

(iv) OMAP may require the OMAP Member and/or the benefit group to obtain services from fee-for-service providers or a PCCM until such time as they can be enrolled in another PHP;

(v) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(G) If the PHP Coordinator approves the PHP's request for Disenrollment because the OMAP Member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following procedures shall apply:

(i) The PHP shall inform the OMAP Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(iv) If an OMAP Member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the plan's PHP Coordinator. A Member may not be disenrolled from the same PHP for a period of more than 12 months. If the Member is re-enrolled after the 12 month period and is again disenrolled for cause, the disenrollment will be reviewed by DHS for further action.

(b) Other Reasons for the PHP's Requests for Disenrollment include the following:

(A) If the OMAP Member is enrolled in the FCHP or MHO on the same day the Member is admitted to the hospital, the FCHP or MHO shall be responsible for said hospitalization. If the Member is enrolled after the first day of the inpatient stay, the Member shall be disenrolled, and the date of

enrollment shall be the next available enrollment date following discharge from inpatient hospital services;

(B) The Member has surgery scheduled at the time their enrollment is effective with the PHP, the provider is not on the PHP's provider panel, and the Member wishes to have the services performed by that provider;

(C) The Medicare Member is enrolled in a Medicare Cost Plan and was in a hospice at the time of enrollment in the PHP;

(D) The Member had End Stage Renal Disease at the time of enrollment in the PHP;

(E) Excluding the DCO, the PHP determines that the OMAP Member has a third party insurer. If after contacting The Health Insurance Group, the Disenrollment is not effective the following month, PHP may contact HMU to request Disenrollment;

(F) If a PHP has knowledge of an OMAP Member's change of address, PHP shall notify DHS. DHS will verify the address information and disenroll the Member from the plan, if the Member no longer resides in the PHP's Service Area. Members shall be disenrolled if out of the PHP's service area for more than three (3) months, unless previously arranged with the PHP. The effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment;

(G) The OMAP Member is an inmate who is serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. This does not include Members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. PHP is responsible for identifying said clients and providing sufficient proof of incarceration to the Health Management Unit for review of the disenrollment request. OMAP will approve requests for disenrollment from PHPs for Members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHP is responsible for inpatient services only during the time an OMAP Member was an inmate;

(H) The Member is in a state psychiatric institution.

(3) OMAP Initiated Disenrollments:

(a) OMAP may initiate and disenroll OMAP Members as follows:

(A) If OMAP determines that the OMAP Member has sufficient third party resources such that health care and services may be cost effectively provided on a fee-for-service basis, OMAP may disenroll the OMAP Member. The effective date of Disenrollment shall be the end of the month in which OMAP makes such a determination. OMAP may specify a retroactive effective date of Disenrollment if the OMAP Member's third party coverage is through the PHP, or in other situations agreed to by the PHP and OMAP;

(B) If the OMAP Member moves out of the PHP's service area(s), the

effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment;

(C) If the OMAP Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project or Children's Health Insurance Program, the effective date of Disenrollment shall be the date specified by OMAP;

(D) If the OMAP Member dies, the effective date of Disenrollment shall be the end of the month following the date of death;

(E) When a non-Medicare Contracting PHP is assumed by another PHP that is a Medicare HMO, OMAP Members with Medicare shall be disenrolled from the existing PHP. The effective date of Disenrollment shall be the day prior to the month the new PHP assumes the existing PHP.

(b) Unless specified otherwise in these rules or in the OMAP notification of Disenrollment to the PHP, all Disenrollments are effective the end of the month after the request for Disenrollment is approved by OMAP;

(c) OMAP shall inform the Members of the Disenrollment decision in writing, including the right to request an Administrative Hearing. Oregon Health Plan Members may request an OMAP hearing if they dispute a disenrollment decision by OMAP;

(d) If Member requests a hearing, the Member will continue to be disenrolled until a hearing decision reversing that Disenrollment has been mailed to the Member.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0420

## Billing and Payment Under the Oregon Health Plan

(1) All billings for Oregon Health Plan Clients to Prepaid Health Plans (PHPs) and to OMAP, shall be submitted within four (4) months and twelve (12) months, respectively, of the date of service, subject to other applicable OMAP billing rules. Submissions shall be made 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 payor;
- (d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of Provider to certify Member's eligibility); or
- (e) TPR. Pursuant to 42 CFR 36.61, 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 payor of last resort and is not considered an alternative resource or third party resource.

(2) Providers must be enrolled with OMAP to be eligible for fee-for-service payment by OMAP. Mental health providers, except Federally Qualified Health Centers, must be approved by the Local Mental Health Authority (LMHA) and the Mental Health and Developmental Disability Services Division (MHDDSD) before Enrollment with OMAP. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260, Provider Enrollment.

(3) Providers, including mental health providers, do not have to be enrolled with OMAP to be eligible for payment for services by PHPs except that providers who have been excluded as Medicare/Medicaid providers by OMAP, HCFA or by lawful court orders are ineligible to receive payment for services by PHPs.

(4) Providers shall verify, before rendering services, that the client is eligible for the Medical Assistance Program on the date of service 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 payor before rendering services. Providers shall inform OMAP Members of any charges for Non-Covered services prior to the services being delivered.

(5) Capitated Services:

(a) PHPs receive a Capitation Payment to provide services to OMAP Members. These services are referred to as Capitated Services;

(b) PHPs are responsible for payment of all Capitated Services. Such services should be billed directly to the PHP, unless the PHP or OMAP specifies otherwise. PHPs may require providers to obtain pre-authorization to deliver certain Capitated Services.

(6) Payment by the PHP to providers for Capitated Services is a matter between the PHP and the 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-authorizations 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 pre-authorization 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 pre-authorization;

(vi) Sending notice of the decision with appeal rights to the OMAP Member when the determination is made to deny the requested service.

(B) PHPs shall make a determination on at least 95% of Valid Authorization requests, within two working days of receipt of an authorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in skilled nursing facility. Authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If an authorization 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 all other pre-authorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within 14 calendar working days of receipt of the request. PHP must make reasonable efforts to obtain the necessary information during that fourteen (14) day period. However, the PHP may use an additional 14 days to obtain follow-up information, if the PHP justifies the need for additional information and how the delay is in the interest of the member. The PHP shall make a determination as the member's health condition requires, but no later than the expiration of the extension. PHPs shall notify OMAP Members of a denial within five (5) working days from the final determination using an OMAP or

Division approved client notice format.

(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 OMAP 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 calendar 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, for which the OMAP Member may be financially responsible. Such notice shall be provided to the OMAP Member and the treating provider within fourteen (14) calendar days of the final determination. The notice to the Member shall be an OMAP or Division approved notice format and shall include information on the PHPs internal appeals process, and the Notice of Hearing Rights (OMAP 3030) shall be attached. The notice to the provider shall include the reason for the denial;

(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 Third Party Resource is based only on a diagnosis, and no Third Party Resource has been documented in the OMAP Member's clinical record;

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

(c) FCHPs and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the OMAP Member receives within the plan, for authorized referral care, and for urgent or emergency services the OMAP Member receives from non-contracted providers. FCHPs and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-

emergent care OMAP Members receive from non-plan providers;

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

(e) PHPs shall be responsible for payment of Covered Services provided by a Non-Participating Provider that were 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 PHP's referral protocols had been followed;

(D) The PHP shall be responsible for payment to Non-Participating Providers (providers enrolled with OMAP that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount that the provider would be paid from OMAP if the client was fee-for-service. 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) OMAP Members enrolled with PHPs may receive certain services on an OMAP fee-for-service basis. Such services are referred to as Non-Capitated Services;

(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 OMAP on an OMAP fee-for-service basis. Before providing services, providers should contact the PHPs identified on the OMAP Member's Medical Care Identification or, for some mental health services, the CMHP. Alternatively, the provider may call the OMAP Provider Services Unit to obtain information about coverage for a particular service and/or pre-authorization requirements;

(c) Services authorized by the PHP or Community Mental Health Program are subject to the rules and limitations of the appropriate OMAP administrative rules and provider guides, including rates and billing instructions;

(d) Providers shall bill OMAP directly for Non-Capitated Services in accordance with billing instructions contained in the provider guides;

(e) OMAP shall pay at the Medicaid fee-for-service 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 provider guides;

(f) OMAP will 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 OMAP, MHDDSD, nor a PHP except as provided for in OMAP rules and provider guides (e.g., Capitated Services that are not included in the nursing facility all-inclusive rate).

(h) FCHPs that contract with non-public teaching hospitals will reimburse those hospitals for Graduate Medical Education (GME), if the hospitals are:

(A) Neither type A nor type B hospitals;

(B) Not paid according to a type A or type B payment methodology; and,

(C) In remote areas greater than 60 miles from the nearest acute care hospital, with a graduate medical student teaching program.

(i) FCHPs 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 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 PCCM receive services on a fee-for-service basis:

(a) PCCMs are paid a monthly Capitation Payment to provide Primary Care Case Management Services, in accordance with OAR 410-141-0410, Primary Care Case Manager Medical Case Management;

(b) PCCMs provide Primary Care Case Management Services for Preventive Services, primary care services, specialty services, inpatient hospital services and outpatient hospital services. OMAP payment for these PCCM Case Managed Services is contingent upon PCCM authorization;

(c) All PCCM Case Managed Services and other services which are not case managed by the PCCM shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP provider guides;

(d) OMAP shall pay at the OMAP fee-for-service rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate provider guides.

(10) OHP Clients who are not enrolled with a PHP or a PCCM receive services on an OMAP fee-for-service basis:

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

(b) All services shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP provider guides;

(c) OMAP shall pay at the OMAP fee-for-service rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate provider guides.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan unless the services are specifically identified in OAR 410-141-0520, Prioritized List of Health Services;

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the Oregon Health Plan Administrative Rules;

(c) Any treatment, service, or item for a condition that is not listed on the currently funded lines 1 through 574 of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (7);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the client's OHP benefit package, are excluded.

(e) Any treatment, service, or item for a condition which is listed as a Condition/Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (7);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or noncovered condition/Treatment Pair;

(g) Services requested by Oregon Health Plan (OHP) Clients in an emergency care setting which after a screening examination are determined not to meet the definition of Emergency Services and the provisions of 410-141-0140;

(h) Services provided to an Oregon Health Plan Client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(i) Services or items, other than inpatient care, provided to an Oregon Health Plan Client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(j) Services received while the OMAP Member is outside the Contractor's service area that were either:

(A) Not authorized by the OMAP Member's Primary Care Provider; or

(B) Not urgent or emergency services, subject to the Member's appeal rights, that the OMAP Member was outside Contractor's service area because of circumstances beyond the OMAP Member's control. Factors to be considered include but are not limited to death of a family member outside of Contractor's service area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those Medically Appropriate to provide reasonable diagnosis and treatment or to enable the Oregon Health Plan Client to attain or retain the capability for independence or self-care. Included would be those services which, upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic Services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the Oregon Health Plan Prioritized List of Health Services;

(c) Services that are limited under the Oregon Medical Assistance program as identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan unless the services are specifically identified in OAR 410-141-0520, Prioritized List of Health Services or elsewhere in this chapter of the Oregon Administrative Rules.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that Oregon Health Plan Clients are informed of:

(a) Clinically appropriate treatment that may exist, whether covered or not;

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065