

# Federally Qualified Health Centers and Rural Health Clinics Rulebook

**Includes:**

- 1) Current Update Information (changes since last update)
- 2) Table of Contents
- 3) Complete set of FQHC/RHC Services Administrative Rules

FQHC/RHC Services Rulebook  
Update Information  
for  
March 15, 2005

**Effective: March 15, 2005**

OMAP updated the FQHC/RHC Services Program Rulebook with the following new rule:

OMAP temporarily adopted OAR 410-147-0365 to provide an alternate payment methodology for the obstetrical (OB) care portion of the Prospective Payment System provided by remote rural and frontier Rural Health Clinics and contingent on federal approval of the State Plan Amendment.

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

**DEPARTMENT OF HUMAN SERVICES**

**MEDICAL ASSISTANCE PROGRAMS**

**DIVISION 147**

**Federally Qualified Health Center (FQHC) and  
Rural Health Clinic (RHC)**

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## **410-147-0000 Foreword**

(1) The Office of Medical Assistance Programs” (OMAP) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.

(3) It is the clinic’s responsibility to understand and follow all OMAP rules that are in effect on the date services are provided.

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on OMAP’s website.

(5) Notification of rule changes are mailed to all affected OMAP providers.

(6) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. OMAP General Rules and the Oregon Health Plan (OHP) Administrative Rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.

(7) The Health Services Commission’s Prioritized List of Health Services is found in the OHP Administrative Rules (OAR 410-141-0520) and defines the services covered under OMAP.

(8) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.

(9) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0020 Professional Services**

(1) Medical, EPSDT, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or Home Health services are not limited except as directed by rules contained in the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules, the General Rules (OAR 410-120-1200), the Oregon Health Plan (OHP) Administrative Rules, and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List; and

(b) Coverage for reasonable diagnostic services to determine a diagnosis for those conditions that falls below the funded portion of the HSC List.

(2) FQHCs and RHCs are eligible for reimbursement of professional services as allowed within the scope of the clinic and within the scope of the practitioner.

(3) All services provided are to be billed using diagnoses that meet national coding standards unless otherwise directed in rule.

(4) Primary Care Case Manager (PCCM) case managed services, as defined in OHP Administrative Rules (OAR 410-141-0000), are included in the above listing of professional services, but cannot be billed as a separate encounter. These services are included in the financial cost reports required during an adjustment to the clinic rate based on change in clinic scope of services.

(5) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC List to determine coverage.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0040 ICD-9-CM Diagnosis Codes**

(1) The appropriate diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(2) Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable radiology including nuclear Medicine and diagnostic ultrasound providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnosis codes may be listed on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(5) The Office of Medical Assistance Programs (OMAP) requires accurate coding and applies the national standards in effect for calendar years 2003 and 2004 set by the American Hospital Association, the American Medical

Association, and the Centers for Medicare and Medicaid Services (CMS) unless otherwise directed in rule.

(6) OMAP has unique coding and claim submission requirements for Administrative Exams and Death With Dignity services. Specific diagnosis coding instructions for these services are provided in OAR 410-147-0240 and 410-147-0260.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0060 Prior Authorization**

(1) Prior Authorization (PA) is not required for services provided within a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the exception of pharmacy services and hospital dentistry. Refer to the "Drugs" section of the FQHC and RHC rules for more information regarding pharmacy prior authorizations.

(2) Clients who are enrolled in a managed care organization (MCO) can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the MCO as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with an MCO, and the MCO denies payment, the Office of Medical Assistance Programs (OMAP) will reimburse for these services under the encounter rate (see OAR 410-141-0120).

(3) If a client is enrolled in an MCO there may be PA requirements for some services that are provided through the MCO. Contact the client's MCO for specifics.

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10-1-04

## **410-147-0080 Managed Care Organizations (MCOs)**

(1) Clinics serving eligible Medical Assistance Program clients who are enrolled in a Managed Care Organization (MCO) require authorization from that MCO prior to providing MCO covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral before providing any services to clients enrolled in an MCO unless the FQHC or RHC have contracted with the MCO to provide MCO covered services. If an FQHC or RHC has an arrangement or contract with an MCO the clinic is responsible for all MCO rules and prior authorization requirements.

(2) Payment for these services is a matter between the FQHC or RHC and the MCO authorizing the services except as otherwise provided in OAR 410-141-0410. If arrangements were not made with the MCO prior to providing the service, the FQHC or RHC will not be reimbursed under the encounter rate, except as outlined in section (3) of this rule (see OAR 410-141-0120).

(3) FQHCs and RHCs can provide family planning services or HIV/AIDS prevention services to eligible Medical Assistance Program clients enrolled in MCOs without authorization or a referral from the MCO. The FQHC and RHC must bill the MCO first. If the MCO will not reimburse for the service, then the clinic may bill OMAP.

(4) MCOs shall execute agreements with publicly funded providers for payment of point-of-contact services as provided in the terms of Oregon's Section 1115 (CMS) Waiver, unless cause can be demonstrated to the Office of Medical Assistance Programs' (OMAP) satisfaction why such an agreement is not feasible, and are billed directly to the appropriate MCO for the following services:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(5) MCOs are responsible for interpretation services.

(6) Maternity Case Management (MCM) services:

(a) Providing MCM services is optional for MCOs;

(b) Before providing MCM services to a client enrolled in an MCO:

(A) Determine if the MCO provides MCM services;

(B) Request the necessary authorizations. Authorization is not necessary for MCOs that do not provide MCM services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0085 Client Copayments**

(1) Copayments for clients on the Oregon Health Plan (OHP) Plus benefit package:

(a) American Indians/Alaska Natives (AI/AN) clients are exempt from copayments;

(b) Copayments may be required for certain populations and services. See OAR 410-120-1230 for specific details;

(c) Copayments for Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) visits are \$5.00 for dental services and \$3.00 for all other services, except as excluded in OAR 410-120-1230;

(d) A client may have more than one copayment during a 24-hour period. For example, if a client is seen for a medical exam and also has a mental health appointment, the client would be required to pay a copayment for both services.

(2) OHP Standard benefit package:

(a) Clients eligible for OHP Standard are exempt from copayments. Refer to OAR 410-120-1230;

(b) The client's OMAP Medical Care ID will indicate if the client is covered on the OHP Standard benefit package.

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8-1-04

## **410-147-0120 Encounter**

(1) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounters that are billed to the Office of Medical Assistance Programs (OMAP) must meet the definition below and are limited to services covered by OMAP. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(2) An encounter is defined as: "A face-to-face contact (except for telephone contacts as outlined in OAR 410-147-0220 and 410-147-0200 -- see section (3) for more information) between a health care professional and a beneficiary eligible for Medical Assistance Program coverage for the provision of Title XIX and Title XXI defined services through an FQHC or RHC within a 24-hour period ending at midnight, as documented in the client's medical record."

(3) Telephone contacts must include all the components of the service when provided face-to-face. Telephone contacts are not at the exclusion of face-to-face.

(4) See OAR 410-147-0140 for information about multiple encounters.

(5) Refer to Table 147-0120-1 and for list of procedure codes used to report encounters. The following services may be considered reimbursable encounters and include any related medical supplies provided during the course of the encounter:

(a) Medical;

(b) Diagnostic: Reasonable diagnostic services are covered for services below the funding line. Once a diagnosis is established and falls below the funding line, no other services are allowed. For example, a client is seen in the clinic, and the diagnosis is a cold, the office visit is covered; however, any additional treatment is not covered;

(c) Addiction, Dental, Medical and Mental Health Screenings;

(d) Dental - Refer to Table 147-0120-2 and Table 147-0125-1 for a list of covered dental procedures;

- (e) Vision;
  - (f) Physical Therapy;
  - (g) Occupational Therapy;
  - (h) Podiatry;
  - (i) Mental Health;
  - (j) Alcohol and Drug;
  - (k) Maternity Case Management;
  - (l) Speech;
  - (m) Hearing;
  - (n) Home Health (limited to areas in which the Secretary has determined that there is a shortage of home health agencies -- Code of Federal Regulations, 405.2417). Home visits for assessment, diagnosis, treatment or Maternity Case Management is not considered home health services and is considered an encounter;
  - (o) Professional services provided in a hospital setting;
  - (p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and OMAP Administrative Rules.
- (6) The following practitioners are recognized by OMAP:
- (a) Physicians;
  - (b) Licensed Physician Assistants;
  - (c) Dentists;
  - (d) Pharm Ds;

(e) Nurse Practitioners;

(f) Nurse Midwives;

(g) Other specialized nurse practitioners;

(h) Registered nurses under the supervision of an MD; and

(i) Other certified or licensed health care professionals or para-professionals including but not limited to mental health and alcohol and drug practitioners for services that are within the practitioner's scope of practice.

(7) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a client has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(8) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies - Code of Federal Regulations 405.2417), and any other ambulatory services covered by OMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(9) Excluded from the definition of OMAP FQHC or RHC encounters are:

(a) Lab, Radiology including nuclear medicine and diagnostic ultrasound services;

(b) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a client is seen at the clinic for a lab test only use the appropriate CPT code. A visit for lab test only visit is not considered a clinic encounter;

(c) Durable medical equipment or medical supplies not generally provided during the course of a clinic visit. For example, diabetic supplies. However,

gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under fee-for-service;

(d) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program;

(e) Administrative medical examinations and report services. Drug samples or other prescription drugs provided to the clinic free of charge are not reimbursable services and cannot be included in the cost of an encounter;

(f) Death with Dignity services;

(g) Emergency services including delivery for pregnant clients that are eligible under the Citizen/Alien-Waived Emergency Medical benefit. Emergency Services for CAWEM is defined in OAR 410-120-1210. Refer to 410-130-0240 for billing information;

(h) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.

(10) Encounters for MCO covered services provided to eligible Medical Assistance Program clients enrolled in MCOs except family planning services or HIV/AIDS prevention services may not be billed to OMAP as an encounter. However, MCO covered services are included in the MCO Supplemental Payment process done by OMAP quarterly. Refer to OAR 410-147-0460 for specific details.

(11) Codes for Encounters:

(a) Due to the unique billing and payment methodology and the implementation of the Health Insurance Portability Accountability Act (HIPAA), OMAP has converted from using a single OMAP unique procedure code to report an encounter to selected CPT/HCPCS codes. The billing guidelines provided in the FQHC and RHC rules limits FQHCs and RHCs to specific CPT/HCPCS codes when reporting an encounter that may not be consistent with national coding standards. This applies only to procedure codes not diagnosis codes. Bill OMAP with the procedure codes indicated in Table 147-0120-1 for FQHC and RHC

services included in the encounter rate. For services that are not included in the encounter rate, refer to the appropriate OMAP provider rules for billing instructions. Refer to Table 147-0120-1 Billing Codes for an Encounter;

(b) When billing for a clinic visit, select the most appropriate CPT/HCPCS procedure code from the code ranges listed in Table 147-0120-1.

(12) It is the Health Services Commission's (HSC) intent to cover reasonable diagnostic services to determine diagnoses on the HSC Prioritized List of Health Services (List), regardless of their placement on the HSC List.

Table 147-0120-1

Table 147-0120-2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

## Table 147-0120-1 FQHC/RHC Encounter Codes & Modifiers

Effective August 1, 2004

FQHCs/RHCs are limited to the procedure codes listed in this Table when billing for services that are included in the Encounter Rate. Codes used as an encounter represent all service provided to a client on the same date of service. The modifiers listed are required when appropriate.

This Table is arranged to improve clarity and is not intended to provide complete guidance on when multiple encounters may be allowed during a single date of service. Please refer to OAR 410-147-0140 for specific information regarding policy on multiple encounters during a single date of service.

The clinical documentation must support the procedure code reported and meet National Coding Standards.

<p>Routine Medical Office Visits:</p> <ul style="list-style-type: none"> <li>• 99201-99350</li> <li>• 99372 or</li> <li>• 99381-99440</li> </ul>	<p>Immunization Administration:</p> <ul style="list-style-type: none"> <li>• 90471</li> </ul> <p><b>Only use 90471 if administration of an immunization is the sole purpose of the clinic visit. Use modifier SL or SK as appropriate.</b></p>	<p>Tobacco Cessation:</p> <ul style="list-style-type: none"> <li>• S9075 or</li> <li>• G9016</li> </ul> <p><b>Only use if it is the sole reason for the visit.</b></p>
<p>Maternity Case Management (MCM):</p> <ul style="list-style-type: none"> <li>• G9012</li> </ul> <p><b>HCPCS G9012 is used for all MCM services</b></p>	<p>Antepartum, Postpartum Visits or Prenatal Care:</p> <ul style="list-style-type: none"> <li>• 99201-99340</li> <li>• 99372 or</li> <li>• 99381-99440</li> </ul>	<p>Delivery Services:</p> <ul style="list-style-type: none"> <li>• 59409</li> <li>• 59514</li> <li>• 59612 or</li> <li>• 59620</li> </ul>
<p>Medication Management:</p> <ul style="list-style-type: none"> <li>• 90862</li> </ul> <p><b>Only use if it is the sole reason for the visit. This code cannot be billed on the same date as a medical visit or treatment/procedure.</b></p>	<p>Addiction Services:</p> <ul style="list-style-type: none"> <li>• H0001-H0002</li> <li>• H0004-H0005</li> <li>• T1006</li> </ul>	<p>Outpatient Mental Health:</p> <ul style="list-style-type: none"> <li>• 90801-90815</li> <li>• 90847-90857</li> <li>• 90862</li> </ul> <p><b>A medical visit with a mental health diagnosis may not be billed on the same date of service as a mental health visit.</b></p>

<p>Fluoride Varnish:</p> <ul style="list-style-type: none"> <li>• D1203 or</li> <li>• D1204</li> </ul> <p><b>Only use if it is the sole reason for the dental visit. If Fluoride Varnish is provided in a medical office visit D1203 or D1204 may not be reported as an encounter code and is included in the medical visit encounter. D1203 or D1204 cannot be billed on the same date of service as another dental procedure.</b></p>	<p>Dental Prophylaxis:</p> <ul style="list-style-type: none"> <li>• D1110-D1203</li> </ul> <p><b>Only use this procedure code if it is the sole reason for the dental visit.</b></p>	<p>Dental Exams:</p> <ul style="list-style-type: none"> <li>• D0120-D0180</li> </ul>
<p>Ophthalmological Services: (Excluding exams for the purpose of prescribing glasses or contacts)</p> <ul style="list-style-type: none"> <li>• 92002-92014</li> </ul>	<p>Eye Exams: (Prescription of glasses or contacts)</p> <ul style="list-style-type: none"> <li>• S0620-S0621</li> </ul> <p><b>Fitting, dispensing and repair is included in the encounter rate paid at the time of the exam. All glasses or contacts must be purchased through OMAPs Vision Supply Contract.</b></p>	<p>Physical &amp; Occupational Therapy:</p> <ul style="list-style-type: none"> <li>• 97001-97004</li> </ul>
<p>Medical/Surgical/Dental Treatment or Service:</p> <p>HCPCS T1015 is used when a treatment or procedure is provided and no other procedure code listed in this table appropriately describes the service.</p>	<p>The following conditions require the use of a modifier for all codes:</p> <p>Family Planning Service - FP</p> <p>Vaccine for Children - SL</p> <p>Immunization for High Risk - SK</p> <p><sup>1</sup>Medicaid EPDST Services - EP</p>	<p>T1015 requires the use of a modifier:</p> <p>For antepartum, postpartum or prenatal visits not described otherwise in this document use modifier TH.</p> <p>For family planning services use modifier FP.</p> <p>All other services use modifier SU. T1015 is a nationally recognized HCPCS code that denotes a per diem encounter rate.</p>

## Table 147-0120-2 OHP Plus Dental Services

- Codes listed in this table are covered services for OHP Plus. Refer to Table 147-0125-1 for a list of covered Dental services for OHP Standard.
- Codes in bold and italics do not require a copayment for adult clients in fee-for-service all other dental services require copayment for clients who are subject to copayments.
- Dental services for FQHCs are billed with ICD-9-CM diagnoses.
- Refer to Table 147-0120-1 for a list of procedure codes used to bill a FQHC/RHC encounter.

<b><i>D0120</i></b>	D0474	D2752	D3353	D5620
<b><i>D0140</i></b>	D0480	D2910	D3950	D5630
<b><i>D0150</i></b>	D0502	D2920	D4210	D5640
<b><i>D0160</i></b>	D1110	D2930	D4240	D5650
<b><i>D0170</i></b>	D1120	D2931	D4241	D5660
<b><i>D0180</i></b>	D1201	D2932	D4245	D5710
<b><i>D0210</i></b>	D1203	D2933	D4260	D5711
<b><i>D0220</i></b>	D1320	D2940	D4261	D5720
<b><i>D0230</i></b>	D1351	D2950	D4268	D5721
<b><i>D0240</i></b>	D1510	D2951	D4341	D5730
<b><i>D0250</i></b>	D1515	D2954	D4342	D5731
<b><i>D0260</i></b>	D1520	D2955	D4355	D5740
<b><i>D0270</i></b>	D1525	D2957	D4910	D5741
<b><i>D0272</i></b>	D1550	D2970	D4920	D5750
<b><i>D0274</i></b>	D2140	D2980	D5110	D5751
<b><i>D0277</i></b>	D2150	D3220	D5120	D5760
<b><i>D0290</i></b>	D2160	D3221	D5130	D5761
<b><i>D0310</i></b>	D2161	D3230	D5140	D5820
<b><i>D0320</i></b>	D2330	D3240	D5213	D5821
<b><i>D0321</i></b>	D2331	D3310	D5214	D5850
<b><i>D0322</i></b>	D2332	D3320	D5410	D5851
<b><i>D0330</i></b>	D2335	D3330	D5411	D5911
<b><i>D0340</i></b>	D2390	D3331	D5421	D5912
<b><i>D0350</i></b>	D2710	D3332	D5422	D5913
<b><i>D0415</i></b>	D2721	D3333	D5510	D5915
<b><i>D0472</i></b>	D2722	D3351	D5520	D5916
<b><i>D0473</i></b>	D2751	D3352	D5610	D5919

D5922	D5985	D7450	D7770	D8220
D5923	D5986	D7451	D7780	D8660
D5924	D5987	D7471	D7910	D8670
D5925	D6930	D7490	D7911	D8680
D5926	D6972	D7510	D7912	D8690
D5928	D6980	D7520	D7920	D8999
D5929	D7111	D7530	D7950	D9110
D5931	D7140	D7540	D7970	D9211
D5932	D7210	D7550	D7980	D9212
D5933	D7220	D7560	D7981	D9220
D5934	D7230	D7610	D7982	D9221
D5935	D7240	D7620	D7983	D9230
D5936	D7241	D7630	D7990	D9241
D5937	D7250	D7640	D7997	D9242
D5951	D7260	D7650	D8010	D9248
D5952	D7270	D7660	D8020	D9310
D5953	D7285	D7670	D8030	D9420
D5954	D7286	D7680	D8040	D9430
D5955	D7287	D7710	D8050	D9440
D5958	D7320	D7720	D8060	D9610
D5959	D7340	D7730	D8070	D9630
D5960	D7350	D7740	D8080	D9930
D5983	D7440	D7750	D8090	D9999
D5984	D7441	D7760	D8210	

## **410-147-0125 OHP Standard Emergency Dental Benefit**

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(2) Services are limited to those procedures listed in Table 147-0125-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) Hospital Dentistry is not a covered benefit for the OHP Standard population except;

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(4) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit.

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8-1-04

## Table 147-0125-1 OHP Standard Dental Services

Effective August 1, 2004

- Codes listed in this table are covered services for the OHP Standard Dental Emergency Benefit.
- Dental services for FQHCs are billed with ICD-9-CM diagnoses.
- Refer to Table 147-0120-1 for a list of procedure codes used to bill a FQHC/RHC encounter.

D0140	D2910	D7220	D9110
D0170	D2920	D7230	D9210
D0220	D2940	D7240	D9215
D0230	D3110	D7241	D9230
D0240	D3220	D7250	D9410
D0250	D3221	D7260	D9420
D0260	D6930	D7270	D9440
D0270	D7111	D7510	
D0272	D7140	D7520	
D0330	D7210	D7911	

## **410-147-0140 Multiple Encounters**

(1) It is intended that multiple encounters will occur on an infrequent basis.

(2) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service.

(3) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.

(4) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;

(d) A mental health and addiction encounter with similar diagnosis;

(e) Any time a client receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.

(5) Medical encounter definitions:

(a) More than one outpatient visit with a medical professional within a 24-hour period for the same diagnosis constitutes a single encounter. For example, a client comes to the clinic in the morning for an examination, and during the examination, the client is diagnosed with

hypertension. The practitioner prescribes medication and asks the client to return in the afternoon for a blood pressure check;

(b) More than one outpatient visits with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. For example, a client comes to the clinic in the morning for an immunization, and in the afternoon, the client falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a client who comes to the clinic for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter;

(c) This does not imply that if a client is seen at a single office visit with multiple problems that multiple encounters can be billed.

(6) The following services may be considered as multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(a) Dental;

(b) Mental health or addiction services unless both services have similar diagnoses, only one encounter can be reported. In addition, if the client is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(c) Ophthalmologic services - fitting and dispensing of eyeglasses is included in the encounter where the practitioner performs a vision exam;

(d) Maternity Case Management MCM:

(A) When a client is newly diagnosed as pregnant and is referred for the initial MCM assessment; or

(B) When a practitioner determines the pregnant client needs nutritional counseling.

(e) Physical or occupational therapy (PT/OT) - If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(f) Immunizations - if no other medical office visit occurs on the same date of service; and

(g) Tobacco cessation - if no other medical or addiction encounter occurs on the same date of service.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0160 Modifiers**

(1) The Office of Medical Assistance Programs (OMAP) uses nationally recognized modifiers for many services. The modifiers listed in the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules represent those that are required.

(2) For a list of all required modifiers: Refer to OAR 410-147-0120 Table 147-0120-1.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0180 Vaccines for Children (VFC) Program**

(1) Federally Qualified Health Centers and Rural Health Clinics are eligible for reimbursement for the administration of vaccines. VFC program services are considered medical services and are included in the definition of an encounter.

(2) Under this federal program certain immunizations are free for clients ages 0 through 18. For more information on how to enroll in the VFC program, call the Office of Human Resources/Health Services and Family Health Services (formerly the Oregon Health Division).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-147-0200 Maternity Case Management Services**

(1) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are eligible for reimbursement for Maternity Case Management (MCM) services. Bill these services using HCPCS code G9012 for each MCM encounter.

(2) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to Medical/Surgical OAR 410-130-0595 for specific requirements of the MCM program.

(3) The primary purpose of the MCM program is to optimize pregnancy outcomes, including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery.

(4) Multiple MCM encounters in a single day cannot be billed as multiple encounters. The practitioner can bill a prenatal visit and a MCM service on the same day only if the MCM service is the initial evaluation visit. After the initial evaluation visit, the practitioner can bill the nutritional counseling MCM service on the same day as a prenatal visit.

(5) The MCM program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month post-partum period;

(c) Is an additional set of services over and above medical management, including perinatal services of pregnant clients;

(d) Allows for billing for intensive nutritional counseling services.

(6) MCM case managers are required to notify the:

(a) Prenatal care provider when:

(A) MCM services have been initiated; and

(B) Any time there is a significant change in the health, economic, social, or nutritional factors of the client.

(b) Health Division for all first-born babies.

(7) In situations where multiple practitioners are seeing one client for MCM services, the case manager must coordinate care to ensure multiple claims are not submitted to the Office of Medical Assistance Programs (OMAP).

(8) Practitioners may bill four case management visits per pregnancy. In addition, if a client is identified as high risk the practitioners may bill six additional case management visits.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0220 Tobacco Cessation**

(1) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are eligible for reimbursement for tobacco cessation services under the encounter rate. Bill these services on a CMS-1500 using diagnosis code 305.1 only and either S9075 or G9016 as appropriate.

(2) Follow criteria outlined in OAR 410-130-0190.

(3) Practitioners may not report Tobacco Cessation, a specific OMAP prevention program, as a separate encounter when a medical, dental, mental health or addiction service encounter occurs on the same date of service.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0240 Administrative Medical Examinations and Reports**

(1) Administrative Medical Examinations and Reports are not reimbursed under the encounter rate. Reimbursement for Administrative Examinations and Reports are through the Office of Medical Assistance Programs (OMAP) fee-for-service program.

(2) See the Administrative Medical Examinations and Reports billing guide for more detailed information on procedure codes and descriptions.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-147-0260 Death With Dignity**

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All claims for Death With Dignity services must be billed directly to the Office of Medical Assistance Programs (OMAP), even if the client is in a managed care plan. Death With Dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-147-0280 Drugs**

Follow criteria outlined in the following:

- (1) Not Covered Services – OAR 410-121-0147.
- (2) Brand Name Pharmaceuticals – OAR 410-121-0155.
- (3) Drugs and Products Requiring Prior Authorization – OAR 410-121-0040.
- (4) Prior Authorization Procedures – OAR 410-121-0060.
- (5) Clozapine Therapy – OAR 410-121-0190.
- (6) Follow criteria outlined in Notation on Prescription – OAR 410-121-0144.
- (7) Practitioner-Managed Prescription Drug Plan (PMPDP) – Follow criteria outlined in OAR 410-121-0030.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0320 Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment**

- (1) The term “required financial documents” in this rule refers to:
  - (a) Cost Statement (OMAP 3027) or Medicare Cost Report for RHC;
  - (b) Cost Statement Worksheet (OMAP 3032);
  - (c) A copy of the clinic’s trial balance;
  - (d) Audited financial statements if totaling more than \$250,000 of Medicaid funds in a calendar year;
  - (e) Depreciation schedules;
  - (f) Overhead cost allocation schedules; and
  - (g) Complete copy of the grant proposal detailing the clinic’s service and geographic scope for FQHCs only.
- (2) For FQHC enrollment with the Office of Medical Assistance Programs (OMAP) a FQHC must receive Public Health Service (PHS) grant funds under the authority of Section 330 as:
  - (a) Migrant Health Center;
  - (b) Community Health Center;
  - (c) Services to Homeless Individuals; or
  - (d) Non-federally funded health centers that PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) determines should be designated as an FQHC (i.e., “Look Alikes”)
- (3) To be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology and to be enrolled as an FQHC, all FQHCs must submit:

(a) Copy of the notice of current grant award or a copy of the letter from CMS designating the facility as a “Look Alike” or designating the facility as a non-federally funded health center;

(b) Office of Medical Assistance Programs (OMAP) Provider Application (OMAP 3117);

(c) Documents showing the clinic’s scope of services;

(d) All required financial documents;

(e) Submit completed Cost Statements (OMAP 3027) one each for medical, dental and mental health. Addiction services are included in mental health costs, Cost Statement Worksheets (OMAP 3032), and the required financial documents to: OMAP;

(f) If an FQHC provides mental health services the clinic must submit a copy of their certification from the Office of Mental Health and Addiction Services (OMHAS);

(g) If an FQHC provides addiction services the clinic must submit a copy of their certification from OMHAS;

(h) A list of all MCO contracts;

(i) List of names for all practitioners working within the FQHC and a list of all individual OMAP provider numbers; and

(j) List of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC or RHC status along with all OMAP provider numbers assigned to these clinics.

(4) RHC Enrollment:

(a) To be eligible for payment under the PPS encounter rate methodology and to enroll as an RHC, all RHCs must meet the following criteria:

(A) The RHC must be designated as an independent RHC. If your clinic is a provider-based RHC in a small rural hospital of less than 50 beds refer to the OMAP Hospital Services rules on enrollment, billing and reimbursement methodology;

(B) For those RHCs that are certified by CMS, the clinic must submit a copy of Medicare's certification as an RHC, an OMAP Provider Application (OMAP 3117), and the required financial documents;

(C) The RHC must maintain Medicare certification and must be in compliance with all Medicare requirements for certification.

(b) The OMAP Provider Application (OMAP 3117) and the required financial documents will be reviewed by OMAP for compliance with program rules prior to enrollment as an RHC;

(c) Submit one of the following to OMAP:

(A) The clinic's completed Medicare Cost Report; or

(B) A completed Cost Statement (OMAP 3027), Cost Statement Worksheets (OMAP 3032), the OMAP Provider Application (OMAP 3117), and the required financial documents to: OMAP.

(d) If an RHC provides mental health services the clinic must submit a copy of their certification from the OMHAS;

(e) If an RHC provides addiction services the clinic must submit a copy of their certification from OMHAS;

(f) A list of all MCO contracts;

(g) List of names for all practitioners working within the FQHC and a list of all individual OMAP provider numbers;

(h) List of all clinics affiliated or owned by the RHC including any clinics that do not have FQHC or RHC status along with all OMAP provider numbers assigned to these clinics.

(5) The OMAP Provider Application (OMAP 3117) and the required financial documents will be reviewed by OMAP for compliance with program rules prior to enrollment as an FQHC;

(6) FQHCs, that are involved with a Sub-recipient, must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

(7) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians, refer to OAR 410-146-0021 for enrollment details;

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0340 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) /Provider Numbers**

(1) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are allowed one clinic number only. Multiple sites are not allowed additional clinic provider numbers unless each site has a different tax identification number.

(2) The Office of Medical Assistance Programs (OMAP) may grant exception to section (1) of this rule upon written request. The request needs to include documentation describing in detail the need for multiple provider numbers and outlining the mechanisms in place to assure no duplication of billings. If OMAP provides multiple clinic numbers and OMAP finds evidence of duplicate billings or failure to use the billing provider number as required, OMAP may terminate the exception for multiple provider numbers upon written notice to the clinic. To request an exception, write to OMAP – Attn: FQHC/RHC Program Manager. Include an explanation about why OMAP should grant the FQHC or RHC an exception.

(3) Once a clinic enrolls as a FQHC or RHC, OMAP may terminate all individual provider numbers for FQHC/RHC practitioners the same date as the FQHC/RHC clinic number is issued unless documentation is provided for individual providers that have separate practice outside of the FQHC or RHC.

(4) If OMAP grants an exception to section (1) of this rule, OMAP will issue the FQHC or RHC a billing provider number for the main administrative site and a separate performing provider number for each clinic site. If the main administrative site also includes a clinic at that same site, that clinic will have two numbers: (1) a billing provider number, and (2) a clinic site provider number. When granted multiple provider numbers, clinics must enter the billing provider number in Field 33 and the clinic site provider number in Field 24K of the CMS-1500 when submitting claims to OMAP. The main administrative office with a clinic site must list the billing provider number in Field 33 and their clinic provider number in Field 24K.

(5) If an FQHC or RHC has several clinic sites and one or more of the clinics are not designated as an FQHC or RHC, the non-FQHC or non-RHC (each individual clinic) must apply for:

(a) A billing provider number; and

(b) Performing provider numbers for each practitioner.

(6) The FQHC/RHC must submit a written request regarding the circumstances of the need for a practitioner to have an individual provider number.

(7) Upon enrollment and each October thereafter, FQHCs and RHCs must submit to OMAP all provider numbers associated with FQHC/RHC practitioners and/or any non-FQHC and non-RHC clinic numbers.

(8) To request an exception for individual provider numbers, write to OMAP – Attn: FQHC/RHC Program Manager. Include an explanation of the circumstances regarding the individual provider numbers.

(9) If an FQHC or RHC operates a retail pharmacy or provides durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS), i.e., diabetic supplies, the clinic must apply for a pharmacy provider number and/or apply for a DME provider number. Providers may only use these numbers when billing for either retail pharmacy or DMEPOS services. The clinic must meet all pharmacy or DME enrollment requirements and must use the rules from the appropriate program billing rules. These services are not included in the encounter rate.

(10) OMAP will not issue clinic provider number(s) until after the encounter rate is established.

(11) Managed Care Organizations (MCO) are required to report all MCO encounters using the FQHC/RHC clinic number and not individual provider numbers.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-04

## **410-147-0360 Encounter Rate Determination**

(1) The Office of Medical Assistance Programs (OMAP) must determine an encounter rate prior to enrolling with the Office of Medical Assistance Programs (OMAP) as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC):

(a) The PPS encounter rate is effective the date OMAP determines the clinic's encounter rate. The encounter rate may be used to bill for services provided on or after the effective date of the FQHC/RHC encounter rate.

(b) For new FQHC or RHC clinics and for OHP covered services provided prior to the establishment of the clinics encounter rate under PPS, bill the service as fee-for-service.

(2) Financial records must be filed prior to enrollment to determine an encounter rate for any new FQHC or RHC providing services for Title XIX or Title XXI clients that wants to enroll with OMAP and is seeking payment as an FQHC or RHC.

(3) To determine an encounter rate as a FQHC, submit all financial documents listed in OAR 410-147-0320 for each of the following services: Medical, Dental and Mental Health. Include addiction services in the Mental Health cost reports.

(4) To determine an encounter rate as a RHC, submit all financial documents listed in OAR 410-147-0320.

(a) OMAP will accept an uncertified Medicare Cost Report.

(b) If the clinic's Medicare Cost Report, provided to OMAP, does not include all covered Medicaid costs provided by the clinic, submit additional cost information to OMAP. OMAP will add these costs back in to the Medicare Cost Report when determining the RHC encounter rate.

(c) OMAP removes the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare rate.

(5) FQHCs or RHCs that have several clinic sites must file the required financial documentation for each clinic site unless specifically exempted in writing by OMAP. See OAR 410-147-0340 regarding multiple provider numbers.

(6) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC sites.

(7) FQHCs and RHCs cannot include costs not associated with Medicaid services. OMAP does not allow the inclusion of indirect or direct costs for services that are not Medicaid covered services such as a social service office and staff in the clinic's cost report/statement.

(8) For out-of-state FQHCs or RHCs the Cost Statements (OMAP 3027) or Medicare Cost Reports for RHCs can only include financial documents for the clinic sites that see Medical Assistance Program clients and only for services provided to Medical Assistance Program clients. Do not include costs associated with other clinics or sites including non-FQHC or RHC, that do not serve Medical Assistance Program clients in the Cost Statements (OMAP 3027) or Medicare Cost Reports for RHCs.

(9) Effective January 1, 2001, OMAP determines FQHC and RHC encounter rates based on the requirements of the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS) payment methodology and BIPA.

(10) OMAP will establish the rate per encounter for an FQHC or RHC, where no previous cost expense exists, will be established from estimated clinic costs on the Cost Statement (OMAP 3027). OMAP can also establish a clinic's encounter rate based on a clinic of similar size and scope.

(11) At any time, if OMAP determines that the costs provided when establishing the encounter rate were inflated, OMAP may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate; and

(b) Impose sanctions as defined in OAR 410-147-0560.

(12) For FQHCs only, effective October 1, 2004, OMAP will split the current single encounter rate into three separate encounter rates:

(a) Medical;

(b) Dental; and

(c) Mental Health. The costs for addiction services will be included in the Mental Health encounter rate.

(13) For FQHCs that existed in 1999 & 2000:

(a) If clinic existed during the original encounter rate determination in 2001, then there would be no cost adjustments except for the MEI when splitting the costs out for each service group; medical, dental, and mental health (includes addiction services) services. For example:

(A) The medical encounter rate would continue to be based on the average costs from 1999 & 2000;

(B) The dental encounter would continue to be based on the average costs from 1999 & 2000;

(C) The mental health and addiction services would continue to be based on the average costs from 1999 & 2000; and

(D) The rate would be adjusted by the MEI for each year from 2001-2004 and applied to each rate.

(14) For FQHCs that started after 1999 & 2000, OMAP will use the cost report used to determine the original encounter rate under PPS.

(15) If a clinic had a clinic or geographic scope change after the initial encounter rate determination, then OMAP would use the appropriate year to determine costs for the change in scope only. For example, if

the scope change was limited to dental, then only the dental cost report could be updated using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(16) When a FQHC shares the same space for multiple services, then OMAP will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(17) A clinic may be exempt from this requirement if a FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to OMAP's FQHC Program Manager for consideration.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-04

## **410-147-0365 Independent Frontier and Remote Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care**

(1) Medicare certified independent RHC, as defined below, may be eligible to request an APM payment for professional services for OB care under the Prospective Payment System (PPS) based on December 1, 2004 RHC OB care rates, contingent upon federal approval of the State Plan Amendment. The intent of the APM encounter rate is to maintain access to OB care in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care equal to PPS rate or higher, not to exceed 100% of reasonable cost.

(2) To be eligible for the APM OB encounter rate, an RHC must be Medicare certified, be independent, must meet all Office of Medical Assistance Programs (OMAP) requirements applicable to an RHC, qualify as either “frontier” or “remote rural” as defined below, and must request to participate in writing pursuant to participation requirements specified in (3) below.

(a) Frontier RHC is defined as:

(i) Located in a frontier county as designated by the Oregon Office of Rural Health; and

(ii) Population density of six people per square mile or less; and

(iii) The clinic serves Medicaid and uninsured clients.

(b) Remote rural RHC is defined as:

(i) Located in a remote rural service area as designated by the Oregon Office of Rural Health; and

(ii) More than 20 miles from a population center of 10,000 or more and is not within a frontier area; and

(iii) The location of the clinic is in a community with less than 10,000 residents; and

(iv) The community has less than 1 obstetrician per 10,000 population; and

(v) The clinic serves Medicaid and uninsured clients.

(3) If the frontier or remote RHC qualifies under (2) in rule and other requirements outlined by OMAP, the clinic must provide OMAP all required documentation necessary to qualify for the OB APM encounter rate.

(a) An eligible RHC must submit a written request to OMAP for the OB APM encounter rate. The written request needs to include all documentation required in (5) below.

(b) RHCs that met the requirements in (2) on December 1, 2004 may bill, using the OB APM encounter rate effective December 1, 2004, provided cost documentation required in (5) is provided to OMAP within 30 days of written request for OB APM; if all documentation is not provided within 30 days of the OB APM request, the OB APM effective date will be the date the request and complete supporting documentation is received by OMAP.

(c) RHCs that meet the requirements in (2) after December 1, 2004 may bill, prospectively under the new OB APM encounter rate from the date the written request to participate and the required supporting documentation is received by OMAP, or the date the required documents are received, whichever is later.

(4) Care status changes:

(a) OMAP reserves the right to request periodic review of utilization, cost reporting and to re-evaluate OB care access in a community to determine the continued need to pay an OB APM encounter rate for frontier and remote rural RHCs;

(b) Prior to making any changes in the RHC's status and rates, OMAP will re-evaluate the following:

(i) If OB care access in a community has changed; and

(ii) If the RHC no longer meets the requirements for the APM; and

(iii) The stability of new providers supplying additional OB care access.

(c) OMAP will give the RHC 90 days notice of change in status and rate;

(d) If OMAP determines that an RHC no longer meets the OB APM requirements, the RHC may request, within 30 days from notification, that OMAP review any additional supporting documentation regarding the determination.

(5) Determining Encounter Rate: The frontier and remote rural RHC requesting an OB APM encounter rate, and meeting the OMAP requirements, shall have its OB care costs carved out from the primary PPS encounter rate as described below. The primary PPS rate for existing clinics would be recalculated subtracting OB direct care costs and placing them in the OB APM calculation. This OB APM encounter rate includes the professional services provided by the RHC associated with pre-natal, delivery (including cesarean section) and post-partum care, up to 60 days post delivery or termination of pregnancy. Qualification for the OB APM encounter rate is not considered a change of scope and the primary PPS encounter rate will only be adjusted by the costs that are moved to the OB APM encounter rate, unless the RHC has never provided OB care prior to enrollment with OMAP. Once the OB APM encounter rate for the RHC is established, the Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM encounter rate.

(a) OMAP will use the information listed below to determine the eligible RHC's initial OB APM encounter rate. First, OMAP will determine the percent of direct care costs associated with OB services provided through the RHC. To determine the percent of direct care costs associated with OB, the clinic must provide the following information for 1999-2000 or the first year OB services were provided with the written request for an OB APM encounter rate:

(i) Total number of clinic encounters;

(ii) Total number of OB care encounters including delivery;

(iii) Physician salary cost.

(l) Physician cost used in this calculation will be the lesser of the clinic provided physician salary or the national average for family practice with OB care.

(II) This cost basis is added to the physician payroll taxes (if any) and retirement and benefits.

(iv) Nurse salary, payroll taxes, retirement and benefits;

(v) Malpractice premiums for the next two years; and

(vi) On-call time.

(b) OMAP will apply the information listed below to determine staff time spent on direct OB care:

(i) Total number of OB care visits divided by the total number of visits;

(ii) OB physician cost that is determined by multiplying the OB care percentage of total visits;

(iii) OB nursing cost that is determined by multiplying the combined nursing staff salaries, payroll taxes, retirement and benefits by the OB care percentage;

(iv) Malpractice premiums that are based on the average costs for the two years after the date the clinic applies for the APM, as projected by the RHC's malpractice carrier;

(v) Clinics providing physician on-call coverage. The cost of on-call time is calculated by:

(I) Reducing total clinic coverage hours per year by the adjusted clinic daily office hours, further reduced by the OB care percentage, and

(II) Reduced by physician vacation hours (minimum of 80 hours per year), and

(III) Calculated at 80 percent of all on-call time, and

(IV) Adjusted on-call hours of coverage, that are multiplied by the fixed rate of \$20.00 per hour.

(c) Indirect costs associated with OB care will not be carved out of the primary PPS encounter rate. However, the percent of OB care services associated with physician and nurse costs will be adjusted in the primary PPS encounter rate to reflect the costs being moved to the OB APM rate.

(d) The RHC is responsible for providing all documentation necessary for OMAP to conduct the calculations described in this rule. Failure to provide necessary documentation with the request for eligibility may result in a delay of the availability of the OB APM encounter rate.

(e) After OMAP has calculated the initial OB APM encounter, including any adjustments to the PPS rate based on the costs covered under the OB alternative payment rate, OMAP will provide the rate information to the RHC.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

3-15-05

## **410-147-0380 Accounting and Record Keeping**

### (1) General Requirements:

(a) The following rules and regulations apply to clinics reimbursed under the Federally Qualified Health Center (FQHC) and Rural Health Clinic Program;

(b) In cases of conflict between the rules contained in section (2) and (3) of this rule, section (2) will prevail over section (3);

(c) FQHCs and RHCs must use the cost principles contained in OMB Circular A-87 or A-122 to determine reasonable costs. Use the circular appropriate to your clinic;

(d) Must adhere to acceptable accounting standards.

### (2) Rules and Regulations:

(a) FQHC and RHC Administrative Rules;

(b) The Office of Medical Assistance Programs (OMAP) General Rules;

(c) Oregon Health Plan (OHP) Administrative Rules;

(d) All other applicable OMAP provider rules.

(3) Cost Principles for State and Local Governments, OMB Circular A-87 and A-122.

### (4) Each FQHC and RHC shall:

(a) Maintain internal control over and accountability for all funds, property and other assets;

(b) Maintain complete client documentation;

- (c) Adequately safeguard from duplicate billings or other routine billing errors;
- (d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;
- (e) Prepare Cost Statements (OMAP 3027) or Medicare Cost Reports for RHCs in conformance with:
  - (A) Generally accepted accounting principles;
  - (B) The provisions of the FQHC and RHC Administrative Rules; and
  - (C) All other applicable rules listed in sections (2) and (3).
- (f) Maintain for a period of not less than five years from the end of the fiscal the year:
  - (A) Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs;
  - (B) Cost Statement Worksheet (OMAP 3032);
  - (C) A copy of the clinic's trial balance;
  - (D) Audited financial statements;
  - (E) Depreciation schedules;
  - (F) Overhead cost allocation schedules; and
  - (G) Financial and clinical records for the period covered by the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs.
- (g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (OMAP 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

(h) Adequately document expenses reported as allowable costs in the records of the clinic or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trip or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over \$25;

(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs for current or previous periods at OMAP's request. These work papers/reports must be completed within 30 days of OMAP's request. An extension of up to 30 days may be granted if the request is made before the end of the original 30 day period. Extensions must be requested in writing;

(j) Ensure that the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs is reconcilable to the audited financial records and encounters must be reconcilable to the Uniform Data Set (UDS) form or other reasonable data OMAP may request. If the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by OMAP;

(k) Do not submit financial documentation to OMAP for FQHC or RHC sites that:

(A) Are not designated as an FQHC or RHC, and/or;

(B) Do not serve Medical Assistance Program clients.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0400 Compensation for Outstationed Eligibility Workers**

- (1) Compensation may be provided for clinics that are eligible for an Outstationed Outreach Eligibility Worker (OSEW).
- (2) Clinics must submit a budget each October to OMAP for review of the clinic OSEW costs for approval before any OSEW compensation is applied to the encounter rate:
  - (a) Any change to the OSEW rate, based on the October budget submission, will be effective January 1<sup>st</sup> of each year;
  - (b) If, it is determined that the OSEW rate is inflated, the clinics OSEW rate will be adjusted effective immediately.
- (3) To determine which part of the OSEW expense should be charged to OMAP, calculate the percentage of the OSEW total time spent performing eligibility services and multiply it by the total reasonable expenses of the OSEW. This portion of the wages and benefits may be charged to OMAP on the Cost Statement (OMAP 3027) or Medicare Cost Report for Rural Health Clinics.
- (4) Expenses allowed for OSEW reimbursement:
  - (a) Travel necessary for OMAP training on OSEW activities;
  - (b) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;
  - (c) Wages for OSEW;
  - (d) Reasonable equipment necessary to perform outreach activities; and
  - (e) Facility costs. Include a description of the facility area used and if its used for any other activity.

(5) OSEW reimbursement is not applied to managed care organization (MCO) visits and will not be included in the quarterly MCO Supplemental Payment.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0420 Re-basing**

(1) Determination of encounter rates effective January 1, 2001 as directed by the Balanced Budget Act (BBA) of 1997 and the Budget Refinement Act of 1999 Prospective Payment System (PPS) was changed for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) clinics. PPS eliminates annual cost reports and retrospective settlements except for managed care organization (MCO) Supplemental Payments.

(2) As directed by the BBA and PPS, the federal government will notify states when clinics can re-base clinic rates. No specific date has been determined by the federal government at this time.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-03

## **410-147-0440 Medicare Economic Index (MEI)**

Effective January 1, 2001, as directed by the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS), and BIPA all encounter rates must be adjusted annually by the Medicare Economic Index (MEI) for the current year. The encounter rate will be adjusted by the MEI effective January 1st of the current year.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-02

## **410-147-0460 Managed Care Organization Supplemental Payments**

(1) Effective January 1, 2001 as directed by the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS), and BIPA, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may be eligible for managed care organization (MCO) Supplemental Payments from the Office of Medical Assistance Programs (OMAP). MCO Supplemental Payments are paid retrospectively on a quarterly basis for services provided during the previous 12 months.

(2) To receive managed care supplemental payments from OMAP the FQHC or RHC must submit the following:

(a) To MCOs:

(A) Claims within the required timelines outlined in the contract with the MCO;

(B) The FQHC or RHC clinic number must be used when submitting all claims to the MCOs.

(b) To OMAP:

(A) Total payments for all services including lab and radiology including nuclear Medicine and diagnostic ultrasound received from the MCO excluding any bonus or incentive payments;

(B) The total number of actual encounters, excluding all lab or radiology including nuclear Medicine and diagnostic ultrasound encounters. The total number of encounters is not the total number of clients assigned to the FQHC or RHC;

(C) All performing provider numbers that any practitioner associated with the FQHC or RHC has. Association refers to a practitioner that works for the FQHC or RHC and has or had a private practice and billed OMAP for services;

(D) A current list of all MCO contracts. Must be updated annually and submitted to OMAP each October.

(3) MCO Supplemental Payment process:

(a) On a quarterly basis OMAP will send FQHCs and RHCs all MCO encounter data received by OMAP electronically in a spreadsheet format along with an explanation letter;

(b) The FQHC or RHC must review the encounter data and determine if it is complete within 30 days. If it is incomplete, the clinic needs to:

(A) Add the missing data to the electronic file and return it with any documentation that can support the missing data to OMAP and the MCO, and;

(B) Verify that the MCO has the correct provider number for the clinic's claims.

(c) Once the data is reviewed and deemed correct by the FQHC or RHC, an interim check will be issued within 30 days for all encounters that OMAP can verify. A letter outlining the settlement and any other pertinent information will accompany the interim check;

(d) The data must be submitted within the timelines provided by OMAP. See the FQHC and RHC rules for the timelines schedule.

(4) The data provided to the FQHCs and RHCs must be carefully reviewed in a timely fashion. If any missing data is not brought to OMAP's attention within the time frames outlined, OMAP will not recalculate an adjustment.

(5) Requests for MCO Supplemental Payments cannot be filed after the end of the required reporting period for that quarter.

(6) Excluded from MCO supplemental payments for clinic services provided to a managed care client when: The clinic does not have a contract or agreement with the MCO and the client is not a patient of

record with that clinic. This does not apply to family planning services, or HIV or AIDS prevention services. For example:

(a) Jane Doe is enrolled with MCO X and is seeking care for the flu at the FQHC or RHC. The FQHC or RHC has a contract with MCO W but not with MCO X and the client is not a patient of record with the FQHC or RHC; this encounter would not be counted in the MCO Supplemental Payments;

(b) John Doe is enrolled with MCO X and is seeking family planning services at the FQHC or RHC. The FQHC or RHC has a contract with MCO W but not with MCO X and the client is not a patient of record with the FQHC or RHC; however, a family planning service would be counted in the MCO Supplemental Payments.

(7) It is the responsibility of the FQHC or RHC to refer managed care clients back to their MCO practitioner.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-03

## **410-147-0480 Cost Statement (OMAP 3027) Instructions**

(1) The Cost Statement (OMAP 3027) is a required form for Federally Qualified Health Center (FQHC) reimbursements.

(2) Rural Health Clinics (RHC) have a choice of submitting either their Medicare Cost Report or the Cost Statement (OMAP 3027). If the RHC files a Medicare Cost Report additional data may be requested by the Office of Medical Assistance Programs (OMAP).

(3) Reimbursement is based upon the actual reasonable allowable cost per encounter as defined in the FQHC and RHC rules. The Cost Statement (OMAP 3027) must be submitted to OMAP:

(a) For established clinics during an adjustment to the clinic's rate based on change in scope of clinic services;

(b) For new clinics refer to OAR 410-147-0360;

(c) If there is a change of ownership the Cost Statement (OMAP 3027) or Medicare Cost Report must be submitted within 30 days from the date of change of ownership.

(4) The Cost Statement (OMAP 3027) must include all documents required by OAR 410-147-0320.

(5) Each section must be completed if applicable.

(6) Page 1 -- Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, the OMAP provider number, and the name of the persons or organizations having legal ownership of the FQHC or RHC;

(b) List all other FQHCs or RHCs, medical practitioners, and suppliers, or entities owned by the FQHC or RHC by the OMAP provider number;

(c) List all physicians and health care practitioners furnishing services to the FQHC or RHC by the OMAP individual provider number;

(d) The Cost Statement (OMAP 3027) must be prepared and signed by the FQHC or RHC accountant and an authorized responsible officer.

(7) Page 2 -- Part A -- FQHC or RHC Practitioner Staff and Visits:

(a) FTE Personnel: List the total number of staff by position and enter a total on line 20;

(b) Encounters: List the number of on-site and off-site encounters by staff and enter a total on line 20.

(8) Pages 3-4 -- Reclassification and Adjustment of Trial Balance of Expenses:

(a) Covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs;

(b) Record expenses for covered medical costs, non-reimbursable program costs, allowable overhead costs and non-reimbursable overhead costs provided by cost centers in columns 1-5 and enter the totals in column 6. Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;

(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC Administrative rules on allowable costs in column 7. Attach documentation/explanation;

(d) Enter the combined reclassified trial balance with the amount of adjustment in column 8;

(e) Enter the totals from each column under Covered Medical Costs on line 21;

(f) Enter the totals from each column under Non-Reimbursable Program Costs on line 29;

(g) Enter totals from each column under Allowable Overhead Costs on line 48;

(h) Enter totals from each column under Non-Reimbursable Overhead Costs on line 61;

(i) Enter the combined totals from lines 21, 29, 48 and 61 on line 62.

(9) Page 5 -- Determinations -- Determination of Overhead Applicable to FQHC and RHC Services:

(a) Part A and B: Enter all totals from the previous pages of the Cost Statement (OMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;

(b) Part C: If applicable, complete by entering the wages for Outstationed Eligibility Workers on line C1, divide the wages by the number of billable Medical Assistance Program encounters to determine the rate per encounter.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065  
10-1-03

## **410-147-0500 Total Encounters for Cost Reports**

(1) Each Federally Qualified Health Center (FQHC) is required to report total encounters as defined in the Bureau of Primary Health Care's Uniform Data System Manual, Definitions. Each Rural Health Clinic is required to report total encounters as defined by Medicare definitions. All encounters, which meet this definition including encounters for clients who are enrolled in a managed care organization, must be included in total encounters. Except for section (2) of this rule. Report total encounter on the required financial documents shown in OAR 410-147-0320. Encounters must be reconcilable with UDS or other comparable reports.

(2) WIC encounters and all costs approved under the WIC contract must be excluded from the cost statement. All encounters generated by patient advocates/ombudsmen and Outstationed Eligibility Workers employed by or under contract with the FQHC or RHC and salary and fringe benefits or contract cost attributable to such workers must be excluded from the required financial documents shown in OAR 410-147-0320. Cost allocation methods must be clearly documented.

(3) All documents, including original tally sheets and summary sheets used to calculate total encounters, and must be maintained for five years:

(a) The original tally sheets must contain the following information:

(A) Client's name;

(B) Date of service; and

(C) Chart number and/or the patient number.

(b) The tally sheets must agree with the summary sheets and the summary sheets total must be the same as the amount reported on the required financial documents shown in OAR 410-147-0320.

(4) All encounters for the Expanded Family Planning Program are included for the total number of encounters.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

## **410-147-0520 Depreciation**

OMB Circular A-87 and A-122, Section 13 is applicable with the following exception: depreciation and amortization must be calculated on a straight line basis less the estimated salvage value. The clinic must use the American Hospital Association guidelines "Estimated Useful Lives of Depreciable Hospital Assets" for determining asset lives when computing depreciation. For assets not covered by the guidelines and with costs of more than \$500 individually and \$500 aggregate, the lives established by the clinic are subject to approval by OMAP. Depreciation and amortization schedules must be maintained.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065  
10-1-02

## **410-147-0540 Related Party Transactions**

(1) Costs of services, facilities, and supplies furnished to a clinic by individuals or organizations related to the clinic by common ownership or control are allowable at the lower of cost excluding profits and markups to the related party or charge to the clinic. Such costs are allowable to the extent that they:

(a) Relate to Title XIX and Title XXI client care;

(b) Are reasonable, ordinary, and necessary; and

(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.

(2) Documentation of costs to related parties shall be made available at the time of an audit or as requested by OMAP. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(3) Rental expense paid to related individuals or organizations for facilities or equipment shall be allowable to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the Federally Qualified Health Centers and Rural Health Clinics Administrative Rules.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065  
10-1-02

## **410-147-0560 Sanctions**

(1) In addition to the Sanctions in the Office of Medical Assistance Programs' (OMAP) General Rules, the following apply to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC):

(a) Failure to comply with OMAP rules specified in the FQHC and RHC Administrative Rules may result in a reduction to the current encounter rate by 50 percent or \$40 per encounter, whichever is less;

(b) Continued noncompliance after an additional 60-day period has elapsed, beginning with the date the encounter rate was reduced as described in section (1) of this rule, may result in the loss of cost-based reimbursement for the period of noncompliance. For Managed Care Organization (MCO) Supplemental Payments, cost settlement will be based on the reduced encounter rate as specified in section (1) of this rule.

(c) Continued noncompliance of more than 120 days after the encounter rate is reduced, as described in section (1)(a) of this rule, may result in loss of any MCO Supplemental Payments and/or disenrollment from OMAP. The FQHC or RHC will not be permitted to re-enroll without first demonstrating to OMAP's satisfaction:

(A) That it is complying with and will continue to comply with all OMAP rules;

(B) Has established acceptable procedures to assure appropriate billing;

(C) Has provided appropriate staff training and established procedures for training staff;

(D) Has established acceptable procedures to assure the adequate maintenance of all financial records;

(E) Has established procedures to ensure appropriate electronic billing.

(2) If multiple clinic numbers are provided and OMAP finds evidence of duplicate billings or failure to use the billing provider number as required, the exception for multiple provider numbers will be terminated upon written notice to the clinic. Contact the OMAP FQHC and RHC Program Manager for details.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-147-0610 Targeted Case Management (TCM)**

- (1) TCM is excluded from the FQHC/RHC encounter rate.
- (2) If the FQHC or RHC is participating in a TCM program, DHS will issue a HCPCS code when the TCM contract is finalized.
- (3) If a modifier is required and is not used, OMAP will deny the claim.
- (4) If the FQHC or RHC is participating in a TCM program, the clinic must notify OMAP in writing and must include the description of the TCM program.
- (5) A client may only participate in a single TCM program. OMAP does not allow Multiple TCM billings. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

## **410-147-0620 Medicare/Medical Assistance Program Claims**

(1) If a client has both Medicare and Medical Assistance Program coverage, providers must bill Medicare first.

(2) Medicare will automatically forward all claims to the Office of Medical Assistance Programs (OMAP) for processing. However, since Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must bill OMAP using the most appropriate code as described in the FQHC and RHC guide, some of these claims may not be processed and paid automatically. If your claim cannot be paid and processed automatically, a Remittance Advice instructing you to rebill OMAP on the CMS-1500 claim form will be sent to you.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill OMAP using a CMS-1500 claim form, but only after that carrier has made payment determination.

(4) When rebilling on a CMS-1500, bill all services for each encounter under the most appropriate code as described in the FQHC and RHC guide. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation code in Field 9 of the CMS-1500 claim form. Refer to CMS-1500 detailed billing instructions.

(5) OMAP payment will be based on the allowable cost per encounter, less the actual Medicare payment amount.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02