

**DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL
ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS**

DIVISION 147

FQHC AND RHC SERVICES

- 410-147-0000 Foreword
- 410-147-0020 Professional Services
- 410-147-0040 ICD-9-CM Diagnosis Codes
- 410-147-0060 Prior Authorization
- 410-147-0080 Managed Care Organizations (MCOs)
- 410-147-0085 Client Copayments
- 410-147-0120 Encounter
- 410-147-0140 Multiple Encounters
- 410-147-0160 Modifiers
- 410-147-0180 Vaccines for Children (VFC) Program
- 410-147-0200 Maternity Case Management Services
- 410-147-0220 Tobacco Cessation
- 410-147-0240 Administrative Medical Examinations and Reports
- 410-147-0260 Death With Dignity
- 410-147-0280 Drugs
- 410-147-0300 Oregon's Family Planning Expansion Project
- 410-147-0320 Provider Enrollment
- 410-147-0340 FQHC and RHC Provider Numbers
- 410-147-0360 Initial Encounter Rate Determination
- 410-147-0380 Accounting and Record Keeping
- 410-147-0400 Compensation for Outstationed Outreach Eligibility Workers
- 410-147-0420 Rebasing
- 410-147-0440 Medicare Economic Index (MEI)

410-147-0460 Managed Care Organization Supplemental Payments
410-147-0480 Cost Statement (OMAP 3027) Instructions
410-147-0500 Total Encounters for Cost Reports
410-147-0520 Depreciation
410-147-0540 Related Party Transactions
410-147-0560 Sanctions
410-147-0580 General Billing and Payment Information
410-147-0600 Instructions on Completing the CMS-1500
410-147-0620 Medicare/Medical Assistance Program Claims

410-147-0000 Foreword

(1) The Office of Medical Assistance Programs' (OMAP) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) guide is 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 guide contains important information including general program policy, provider enrollment, 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 guides 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 guides can be found on OMAP's website.

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

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

(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) (formerly the Health Care Financing Administration (HCFA)) 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

Hist.: Hist.: AFS 20-1988, f. 3-8-88, cert. ef. 4-1-88; AFS 16-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 29-1991(Temp), f. & cert. ef. 7-1-91; HR 33-1991, f. & cert. ef. 8-16-91; Renumbered from 461-0014-415; HR 12-1992, f. & cert. ef. 4-1-92; HR 24-1992, f. & cert. ef. 7-3-92; HR 13-1996(Temp), f. & cert. ef. 7-1-96; HR 24-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0000; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0000

410-147-0020 Professional Services

(1) Medical, 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) guide, 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 fall 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 at the time of rebasing.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0500; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0140

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 X-ray 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 2002 and 2003 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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0020; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0060

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. Refer to the "Drugs" section of the FQHC and RHC guide for more information.

(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, these services will be reimbursed under the encounter rate through the Office of Medical Assistance Programs (OMAP) (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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0640; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0080

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.

(4) Unless cause can be demonstrated to the Office of Medical Assistance Programs' (OMAP) satisfaction why such an agreement is not feasible, 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, 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

Hist.: HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0155; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0100

410-147-0085 Client Copayments

(1) American Indian/Alaska Natives (AI/AN) are not required to pay copayments for services provided through Indian Health Services (IHS), a Federally recognized Indian Tribe, Tribal Organization or services provided at an Urban Tribal Health Clinic. This includes any health care services provided to the AI/AN member and is defined as provided directly, by referral, or under contracts or other arrangements between IHS, a Federally recognized Indian Tribe, Tribal Organization or an Urban Tribal Health Clinic and another health care provider. Refer to OAR 410-120-1230 and 410-120-1235 in the General Rules, and OAR 410-146-0075 in the AI/AN program administrative rules.

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

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

(b) Copayments for Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) visits are \$3.00, except as excluded in OAR 410-120-1230.

(3) Copayments for clients on the OHP Standard benefit package:

(a) Clients on OHP Standard may be subject to copayments for services provided by an FQHC or RHC;

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

(c) FQHCs and RHCs are required to collect copayments from OHP Standard clients, including those enrolled in managed care, for any services requiring a copayment.

(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. The service categories in the FQHC and RHC Guide that can incur multiple copayments in a 24-hour period are:

(A) Primary care services;

(B) Ophthalmological services for medical reasons;

(C) Physical therapy;

(D) Occupational therapy;

(E) Dental services -- Effective March 1, 2003, dental services are no longer covered in the OHP Standard benefit package;

(F) Outpatient mental health services -- Effective March 1, 2003, outpatient mental health services are no longer covered in the OHP Standard benefit package; and

(G) Alcohol and drug treatment/counseling services -- Effective March 1, 2003, alcohol and drug/counseling services are no longer covered in the OHP Standard benefit package.

(e) Excluded Services and Limitations -- The following services are not covered for clients on the OHP Standard benefit package:

(A) Vision services for the purpose of prescribing glasses or contacts. Note: Eye exams used for medical reasons such as diabetes, glaucoma or trauma are covered;

(B) Glasses, contacts, or any repair or replacement;

(C) Select dental services -- (See OAR 410-123-1085):

(i) Clients are limited to a maximum of \$500.00 for dental services within a six month calendar year. A six month calendar year is defined as January 1 through June 30 and July 1 through December 31;

(ii) \$500.00 maximum dental benefit is calculated based on OMAP dental fee-for-service rates, minus copayment, minus third party resource payments. It is the responsibility of the clinic to track dental expenditures for clients of record.

(D) Effective March 1, 2003, the following services are also no longer covered in the OHP Standard benefit package:

(i) Dental services;

(ii) Outpatient mental health services;

(iii) Alcohol and drug treatment/counseling services.

(E) All services listed in OAR 410-120-1200 and OHP Rule 410- 141-0500.

(f) Copayment requirements for clients on the OHP Standard benefit package:

(A) Fee-for-service clients:

(i) All clinic encounters require a \$5.00 copayment, except dental encounter visits which are \$10.00;

(ii) Laboratory and radiology services require a \$3.00 copayment.

(B) Managed Care Organization (MCO) clients. It is the responsibility of the FQHC or RHC clinic to collect the appropriate copayment for clients enrolled in an MCO (see OAR 410-120-1235 and 410-123-1085).

(g) Services exempt from copayment requirements, see OAR 410-120-1235.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 90-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03

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) The following services are considered reimbursable encounters and include any related medical supplies provided during the course of the encounter:

(a) Medical;

(b) Diagnostic;

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

(d) Dental;

(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 are not considered home health services and are considered an encounter;

(o) 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 licenced 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 and X-Ray services;

(b) 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;

(c) 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;

(d) Administrative medical examinations and reports services;

(e) Death with Dignity services;

(f) 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 guide 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 each service category 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 guide for billing instructions;

(b) When billing for a clinic visit, select the most appropriate CPT/HCPCS procedure code from the code ranges shown in the following categories. If a procedure code is listed within a category that defines the level of service provided, the expectation is to use National Coding Standards. For categories that are not listed below use an office visit code listed in the primary care services section:

(A) For primary care services: Use CPT codes 99201-99340, 99372 or 99381-99440 for most primary care services provided to all age groups including clozaril management services. Effective April 1, 2003, use CPT 90862 for clozaril management;

(B) For immunizations: Use CPT 90471 when administration of an immunization is the sole purpose of the clinic visit;

(C) For delivery services: Use CPT codes 59409, 59514, 59612 or 59620 to report delivery services. These codes cannot be used for prenatal, antepartum or postpartum services. When billing for prenatal, antepartum or postpartum visits select the most appropriate CPT code listed under primary care services;

(D) For maternity case management (MCM): Use HCPCS code G9012 to report all MCM encounters. See OAR 410-147-0200 for definition of services;

(E) Ophthalmological services: Use CPT codes 92002-92014 for these services including routine eye exams for the purpose of glasses or contacts;

(F) Eye glasses: Use CPT codes 92340-92353 or 92370-92371 for the fitting, dispensing and repair of glasses;

(G) For physical therapy and occupational therapy: Use CPT codes 97001-97004 for all physical medicine and rehabilitation services;

(H) For dental services: Use HCPCS codes D0120-D0180 or D1110-D1203. Fluoride varnish treatment must be billed using D1201 or D1203. Effective March 1, 2003, dental services are no longer covered in the OHP Standard Benefit Package;

(I) For outpatient mental health services: Use CPT codes 90801-90899 excluding clozaril management. For clozaril management see codes listed under primary care services;. Effective March 1, 2003, outpatient mental health services are no longer covered in the OHP Standard Benefit Package. Effective April 1, 2003, use CPT 90862 for clozaril management;

(J) For alcohol and drug services: Use HCPCS codes H0001-H0007. Effective March 1, 2003, alcohol and drug services are no longer covered in the OHP Standard Benefit Package;

(K) Tobacco cessation: Use HCPCS codes S9075 or G9016 that meet the criteria outlined for tobacco cessation;

(L) 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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0390; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0150; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03

410-147-0140 Multiple Encounters

(1) Certain conditions allow for multiple encounters for the same client on the same date of service. Each service must be a distinct different service. For example, a medical visit and a dental visit on the same day is considered two distinct different services. A well child check and an immunization on the same day would not be considered multiple encounters.

(2) The following is a list of categories that are generally considered distinct different services:

(a) Medical:

(A) More than one outpatient visit with a medical professional within a 24-hour period for the same diagnosis constitutes a single encounter;

(B) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses report as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that multiple encounters can be billed;

(b) Dental;

(c) Mental Health;

(d) Alcohol and Drug;

(e) Ophthalmological services or fitting and dispensing of eye glasses;

(f) Maternity Case Management -- initial visit and evaluation;

(g) Physical or Occupational Therapy;

(h) Immunizations -- if no other medical office visit occurs; and

(i) Tobacco cessation.

(3) OMAP considers more than one outpatient visit with a medical professional within the same date of service for the same condition a single medical encounter. For example, a client comes to the clinic in the morning for an examination, 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.

(4) OMAP considers more than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses multiple medical encounters. For example, a client comes to the clinic in the morning for an immunization and in the afternoon falls and breaks an arm. These would be considered multiple medical encounters and can be billed as two encounters. However, a client that comes to the clinic for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinct different diagnosis and can only be billed as a single encounter. (5) When billing for two separate encounters on the same date of service using the same office visit code for distinctly different diagnosis codes bill on separate lines with the appropriate diagnosis code with a quantity of one.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0520; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0155

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) guide represent those that will be required April 1, 2003. OMAP urges clinics to begin using all appropriate modifiers when billing for services. However, only the modifiers listed below will be required April 1, 2003.

(2) Modifiers:

(a) 25 -- Significant, separately identifiable evaluation and management service by the same practitioner (clinic) on the same day of the procedure or other service. This modifier should be used when two distinct medical services are provided on the same day as defined in OAR 410-147-0140;

(b) FP -- Family Planning Services. This modifier is to be used when providing primarily family planning services;

(c) SK -- Member of high risk populations. This modifier is to be used for high risk clients receiving recommended immunizations;

(d) SL -- State Supplied Vaccine. This modifier is to be used when providing a Vaccine for Children immunization;

(e) TA -- OB/Prenatal care. This modifier is to be used when providing OB/Prenatal care only and is not to be used for MCM services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

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

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0540; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0160

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. These services are billed using HCPCS code G9012 for each MCM encounter.

(2) 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 and no later than the day prior to delivery. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the MCM initial evaluation has not been completed prior to the day of delivery.

(3) Multiple MCM encounters in a single day cannot be billed as multiple encounters. A prenatal visit and a MCM service on the same day can be billed as two encounters only if the MCM service is the initial evaluation visit. After the initial evaluation visit the nutritional counseling MCM service can be billed on the same day as a prenatal visit.

(4) 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.

(5) 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.

(6) MCM services are not to occur on the same date of service as prenatal services except the initial assessment and nutritional counseling.

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

(8) Definitions:

(a) Case Management -- An ongoing process to assist the client in obtaining access to and effective utilization of necessary health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;

(b) Case Management Visit -- A client encounter that must include two or more specific training and education topics and provides ongoing relationship development between the client and the case manager. May be provided in the client's home or other site;

(c) Client Service Plan (CSP) -- A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment and includes a client discharge plan/summary;

(d) High Risk Client -- Includes clients who have current (within the last year) documented alcohol, tobacco, or other drug (ATOD) abuse history, or who are 17 or under, or have other conditions identified in the initial assessment instrument;

(e) Home/Environmental Assessment -- A visit to the client's primary place of residence to assess health and safety of the client's living conditions;

(f) Initial Assessment -- Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths, in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas. Data sources may include:

(A) Initial assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client.

(g) Nutritional Counseling -- Intensive nutritional counseling for clients who have at least one of the following documented conditions:

(A) Chronic disease, e.g., diabetes, renal disease;

(B) Hematocrit (Hct) less than 34, (Hemoglobin (Hgb) 11) first trimester, Hct 32 (Hgb10) second or third trimester;

(C) Pre-gravida weight under 100 lbs or over 200 lbs;

(D) Pregnancy weight gain outside WIC guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

(H) Pregnancy induced hypertension (preeclampsia);

(I) Other conditions identified by the maternity case manager, physician, or perinatal care provider for which adequate services are not accessible through another program.

(h) Prenatal/Perinatal Care Provider -- The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and or postnatal services to the client;

(i) Telephone Contact -- A non-face-to-face client encounter between a maternity case manager and the client, initiated by the maternity case manager, providing education or training related to the CSP and are limited to Case Management Visits only. 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. Services excluded from telephone contacts are: Initial Assessment, Home Assessment and Nutritional Counseling.

(9) Maternity Case Manager Qualifications:

(a) Maternity case managers must be currently licensed as a:

(A) Physician;

(B) Physician Assistant;

(C) Nurse Practitioner;

(D) Certified Nurse Midwife;

(E) Direct Entry Midwife;

(F) Social Worker; or

(G) Registered Nurse with a minimum of two years related and relevant work experience.

(b) Other para professionals may provide specific services while working under the supervision of one of the providers listed in (9)(a) of this rule;

(c) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(10) Nutritional Counselor Qualifications -- A nutritional counselor must:

(a) Be a registered dietician; or

(b) Have a bachelor's degree in a nutrition related field with two years of related work experience.

(11) Documentation Requirements:

(a) Documentation is required for all MCM services in accordance with OMAP General Rules OAR 410-120-1360; and

(b) A correctly completed OMAP form 2470, 2471, and 2472, or their equivalents meet minimum documentation requirements for MCM services.

(12) Initial Assessment -- Is required of all clients prior to other MCM services. Initial Assessments can be done on the same date of service as a prenatal visit:

(a) Includes:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP which addresses needs identified;

(C) Making referrals as needed;

(D) Assisting with a referral to a prenatal care provider as needed;

(E) Forwarding of the initial assessment and other relevant information to the on-going maternity case manager and prenatal care provider;

(F) Communicating pertinent information to others participating in the client's medical and social care.

(b) Client's record must reflect the date and to whom the initial assessment was sent;

(c) Paid one time per pregnancy per provider.

(13) Case Management -- Includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

(A) The client's records must include a CSP and written updates to the plan;

(B) The CSP activities involve determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager.

(c) Referral to services included in the CSP:

(A) Make referrals, provide information and assist the client in self-referral;

(B) Maintain contact with resources to ensure service delivery, share information, and assist with coordination.

(d) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling as indicated;

(e) Training, information, and education on the following:

(A) Maternal/Fetal HIV transmission prevention;

(B) Early childhood caries prevention;

(C) Tobacco use and exposure;

(D) Lead exposure and screening; and

(E) Immunizations.

(f) Linkage to labor and delivery services;

(g) Linkage to family planning services as needed;

(h) CSP coordination as follows:

(A) Contact with Department of Human Services worker, if assigned;

(B) Contact with prenatal care provider;

(C) Contact with other community resources/agencies to address needs.

(i) Client advocacy as necessary to facilitate access. The case manager serves as a client advocate and intervenes with agencies or persons to help the client receive appropriate benefits or services;

(j) Assist client in achieving the goals in the CSP. The case manager will advocate for the client when resources are inadequate or the service delivery system is non-responsive.

(14) Nutritional Counseling -- May be provided on the same date of service as a prenatal visit:

(a) Available for clients who have at least one of the documented conditions listed in the "Definitions" section of this rule;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up.

(c) Paid one time per pregnancy.

(15) Home/Environment Assessment:

(a) Includes an assessment of the health and safety of the client's living conditions with training and education as indicated in the following areas (must include all topics):

(A) Housing and living situation:

(i) General condition of house;

(ii) Number of bedrooms (vs. number of people);

(iii) Food storage facilities;

(iv) Food preparation facilities;

(v) Adequacy of shelter;

(vi) Heating/cooling/ventilation;

(vii) Sanitation/sewer;

(viii) Running water;

(ix) Phone service.

(B) Safety:

- (i) Guns (locked and unloaded);
- (ii) Smoke alarm (installed and working);
- (iii) Fire prevention (e.g., smoking habits, if applicable);
- (iv) Adequate exits from all locations and free of obstacles.

(C) Exposure to toxins, such as:

- (i) Exposure to lead (peeling paint, lead pipes, lead dust);
- (ii) Chemical use in or near home;
- (iii) Asbestos.

(D) Pet health issues, such as:

- (i) Cats (Toxoplasmosis);
- (ii) Birds (Psittacosis);
- (iii) Reptiles (Salmonella), i.e., iguanas, turtles, snakes.

(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems and necessary follow-up or when client moves.

(16) Telephone Contact:

(a) A non-face-to-face client encounter between a maternity case manager and the client, initiated by the maternity case manager, providing education or training related to the CSP when a face-to-face case management visit is not possible or practical;

(b) If the telephone contact is more than half of the allowed home visits the client records must have specific details on why the case manager could not provide more face-to-face contacts;

(c) Telephone contact in the MCM program is a tool to improve client contact for case management services when specific barriers prevent adequate face-to-face services and are not for the convenience of the case manager;

(d) Telephone contacts must include all the components of the service when provided face-to-face;

(e) Telephone contacts are not at the exclusion of face-to-face.

(17) Case Management Visit:

(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and training, information and education regarding at least two of the following topics:

(A) Pre-term birth prevention:

(i) Factors associated with increased risk;

(ii) Early detection of symptoms;

(iii) Obtaining help/information;

(iv) Stress reduction.

(B) Pregnancy and childbirth:

(i) Common discomforts of pregnancy;

(ii) Pregnancy danger signs and symptoms;

(iii) Labor and birth process;

(iv) Coping strategies;

(v) Common interventions;

(vi) Emergencies.

(C) Health status:

(i) Rest/exercise;

(ii) Digestive tract changes;

(iii) Nutrition;

(iv) Weight gain;

(v) Food availability;

(vi) Food selection/preparation;

(vii) Nutrient/calorie intake;

(viii) Medications;

(ix) Oral health needs during pregnancy and for the newborn.

(D) Environment:

(i) Health adequacy, safety, and sanitation;

(ii) Environmental hazards;

(iii) Toxins/Teratogens.

(E) Emotional:

(i) Stress reduction;

- (ii) Coping strategies;
- (iii) Hormonal changes;
- (iv) Relationships.
- (F) Family planning;
- (G) Sexually transmitted diseases;
- (H) Substance/alcohol use;
- (I) Infant care/parenting:
 - (i) Feeding/nutrition/infant growth;
 - (ii) Clothing needs;
 - (iii) Infant sleep patterns and location;
 - (iv) Wellness care/immunizations;
 - (v) Breastfeeding;
 - (vi) SIDS and Back To Sleep;
 - (vii) Developmental milestones;
 - (viii) Common interventions;
 - (ix) Emergencies;
 - (x) Safety;
 - (xi) Infant/parent interaction;
 - (xii) Bonding/attachment;

(xiii) Infant communication patterns/cues;

(xiv) Parental frustration/sleep deprivation;

(xv) Household management support;

(xvi) Community resources;

(xvii) Child nurturing/protection.

(b) Four Case Management Visits may be billed per pregnancy;

(c) Six additional Case Management Visits may be billed if the client is identified as High Risk.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0560; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0180

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. These services are billed 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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0580; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0200

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

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-620; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0220

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

Hist.: OMAP 16-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 27-1999, f. & cert. ef. 6-4-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0035; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0260

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.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0600; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0240

410-147-0300 Oregon's Family Planning Expansion Project

(1) To curb a growing crisis in access to public family planning services and as part of Oregon's Action Agenda for Teen Pregnancy Prevention, the Office of Human Resources/Health Services and Family Health Services (OHR/HSFHS) (formerly the Oregon Health Division (OHD)) and the Office of Medical Assistance Programs (OMAP) have jointly implemented the Oregon Family Planning Expansion Project (FPEP) for low income Oregonians, and teens.

(2) The goal of the FPEP is to reduce unintended pregnancies and improve the well-being of children and families. The goals and objectives of the FPEP are aligned with related national and state family planning and maternal child health objectives including the National Healthy People 2010 objectives and the Oregon Benchmarks.

(3) Any FQHC or RHC that wants to participate in the FPEP must contact the OHR/HSFHS for an application and eligibility requirements to participate in the FPEP program.

(4) Reimbursement of services for FPEP clients is limited to the services outlined in the FPEP Program Manual. FPEP clients do not have Medicaid ID numbers and are not eligible for any Medical Assistance Program services.

(5) All claims related to the FPEP must be submitted to OHR/HSFHS for reimbursement as outlined in the FPEP Program Manual. Do not submit claims to OMAP for services provided under the FPEP program.

(6) It is the responsibility of the FQHC or RHC to provide a copy of OMAP's letter outlining the current encounter rate to OHR/HSFHS. In addition, clinics must provide an updated copy to OHR/HSFHS after each rebasing. The effective date for the new encounter rate through FPEP will be the effective date outlined in the letter from OMAP or the date of receipt if the FQHC or RHC fails to provide OHR/HSFHS a copy in a timely fashion.

(7) All services outlined in the current FPEP Program Manual provided to an FPEP client on the same date of service through the FPEP Program are considered distinct services. If an FPEP client has other primary care services provided on the same date of service as an FPEP service it would be considered a separate service and be counted as two encounters.

(8) Refer to OAR 410-147-0500 for additional information regarding cost reports and the FPEP program.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0680

410-147-0320 Provider Enrollment

(1) Note: The term "required financial documents" in this rule refers to:

(a) Cost Statement (OMAP 3027) or Medicare Cost Report for Rural Health Clinics (RHC);

(b) Cost Statement Worksheet (OMAP 3032);

(c) A copy of the clinic's trial balance;

(d) Audited financial statements if more than \$250,000 total Medicaid funds in a calendar year;

(e) Depreciation schedules;

(f) Overhead cost allocation schedules; and

(g) A list of all clinic provider numbers and any other provider numbers associated with the Federally Qualified Health Center (FQHC) or RHC. See OAR 410-147-0340 for details;

(h) Complete copy of the grant proposal detailing the clinic's service and geographic scope for FQHCs only.

(2) FQHC Enrollment:

(a) To be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology and to be enrolled as an FQHC, all FQHCs must meet the following criteria:

(A) For those centers receiving Public Health Services (PHS) grant funds under authority of Section 330 -- Migrant Health Centers, Community Health Centers, or Services to Homeless Individuals, the clinic must submit a copy of the notice of current grant award, an Office of Medical Assistance Programs (OMAP) Provider Application

(OMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(B) For those non-federally funded health centers that PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) determines, should be designated as an FQHC (i.e., "Look Alikes"), the clinic must submit 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, an OMAP Provider Application (OMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(C) For those non-federally funded health centers that CMS determines may, for good cause, qualify through waivers of CMS requirements, the clinic must submit a copy of the letter from CMS designating the facility as a "Look Alike," an OMAP Provider Application (OMAP 3117), documents showing the clinic's scope of services, and the required financial documents. Waivers may be granted for up to two years;

(D) For those 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, the clinic must submit a copy of the award/contract from the Indian Health Services with an OMAP Provider Application (OMAP 3117), documents showing the clinic's scope of services, and the required financial documents.

(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 FQHC;

(c) Submit completed Cost Statements (OMAP 3027), Cost Statement Worksheets (OMAP 3032), and the required financial documents to: OMAP;

(d) 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);

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

(f) A list of all MCO contracts;

(g) List of all OMAP provider numbers of practitioners working within the FQHC;

(h) 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.

(3) 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 guide for 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.

(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 all OMAP provider numbers of practitioners working within the RHC;

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

(4) Tribal Facility Enrollment:

(a) Any Indian Health Service facility, federally recognized Indian tribe, tribal organization or FQHCs with a 638 designation, excluding Urban Tribal Clinics, that provides health care services as defined in rule may choose to enroll as either an FQHC or an American Indian/Alaska Native (AI/AN) clinic provider;

(b) If the FQHC eligible Tribal Facility chooses to enroll as an FQHC provider the clinic must follow the enrollment and program rules contained in the FQHC and RHC guide. As an FQHC the clinic is not eligible for benefits under the Memorandum of Agreement;

(c) If the FQHC eligible Tribal Facility chooses to enroll as an AI/AN provider that clinic must follow the enrollment and program rules contained in the AI/AN billing guide;

(d) Tribal administrative match is not allowed under the FQHC program and is considered a part of costs associated with Medicaid services contained in the encounter rate;

(e) Any FQHC with a Title V designation serving as an Indian Tribal Health Center must enroll as an FQHC. Refer to the FQHC enrollment requirements.

(5) Subrecipient contracts with either an FQHC or RHC must enroll either as an FQHC or RHC and submit the same required documentation as outlined under the FQHC and RHC enrollment sections of this rule.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0010

410-147-0340 FQHC and 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) FQHCs and RHCs are required to submit to the Office of Medical Assistance Programs (OMAP) all provider numbers associated with non-FQHC and non-RHC clinics and provider numbers for practitioners that have or had a private practice with an active OMAP provider number upon enrollment and annually thereafter. In addition a list of all OMAP provider numbers of all employees of the FQHC or RHC including any inactive provider numbers.

(3) OMAP may grant exception to section (1) of this rule upon written request from the FQHC or RHC. The request needs to include documentation from the FQHC or RHC describing in detail the need for multiple provider numbers and outlining the mechanisms in place to assure no duplication of billings. 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.

(4) To request an exemption write to OMAP -- Attn: FQHC/RHC Program Manager. Include an explanation about why the FQHC or RHC should be exempt.

(5) If OMAP grants an exception to section (1) of this rule the FQHC or RHC will be issued 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 has a clinic at that site that clinic will have two numbers (1) billing provider number (2) clinic site provider number. When granted multiple provider numbers clinics are required to 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.

(6) 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.

(7) If an FQHC or RHC operates a retail pharmacy or provides durable medical equipment, 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. These provider numbers may only be used 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 guide. These services are not included in the encounter rate.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

410-147-0360 Initial Encounter Rate Determination

(1) An encounter rate must be determined prior to enrollment with the Office of Medical Assistance Programs (OMAP) as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

(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 for Title XIX or Title XXI services and is seeking payment as an FQHC or RHC.

(3) To determine an encounter rate as an:

(a) FQHC, submit the following:

(A) Cost Statement (OMAP 3027);

(B) Cost Statement Work Sheet (OMAP 3032);

(C) A copy of the grant or other documents showing FQHC status;

(D) A copy of documentation showing the clinic's scope of services;

(E) A copy of documentation showing the geographic scope of services;

(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 all OMAP provider numbers of practitioners working within the FQHC;

(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.

(b) RHC, submit the items listed in (A) or (B):

(A) A copy of:

(i) Uncertified Medicare Cost Report;

(ii) Certification as an RHC;

(iii) Documentation showing the clinic's scope of services;

(iv) Documentation showing the geographic scope of services.

(B) A copy of:

(i) Cost Statement (OMAP 3027);

(ii) Cost Statement Work Sheet (OMAP 3032);

(iii) Certification or other documents showing RHC status;

(iv) Documentation showing the clinic's scope of services;

(v) Documentation showing the geographic scope of services;

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

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

(viii) A list of all MCO contracts;

(ix) List of all OMAP provider numbers of practitioners working within the RHC;

(x) 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.

(4) If the RHC chooses to submit a copy of their Medicare Cost Report there may be additional information OMAP will request.

(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 for information regarding multiple provider numbers.

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

(7) FQHCs and RHCs cannot include any costs not associated with Medicaid services.

(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. Costs associated with other clinics or sites including non-FQHC or RHC, that do not serve Medical Assistance Program clients cannot be included 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) 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), or Medicare Cost Report for RHCs, or can be established 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) Sanctions may be imposed as defined in OAR 410-147-0560.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

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 sections (2) and (3) of this rule, section (2) will prevail over section (3);

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

(d) Adherence 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 Guides.

(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 year the:
 - (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 which states the purpose of the trip or activity, the dates, the 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) Not submit financial documentation to OMAP for any 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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0080

410-147-0400 Compensation for Outstationed Outreach Eligibility Workers

- (1) Compensation may be provided for clinics that are eligible for an Outstationed Outreach Eligibility Worker (OOEW).
- (2) Clinics must submit a budget during rebasing for their OOEW costs for the Office of Medical Assistance Program's (OMAP) approval before any OOEW compensation is applied to the encounter rate.
- (3) To determine which part of the OOEW's expense should be charged to OMAP, calculate the percentage of the OOEW's total time spent performing eligibility services and multiply it by the total reasonable expenses of the OOEW. 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) OOEW 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

Hist.: HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0330

410-147-0420 Rebasing

(1) Determination of encounter rates effective January 1, 2001 as directed by the Balanced Budget Act 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) For the purpose of clarity this process will be referred to as rebasing. In addition PPS requires the encounter rate to be adjusted annually by the published Medicare Economic Index (MEI) for each calendar year. PPS also allows for MCO Supplemental Payment on a quarterly basis. MCO supplemental payments are independent of the encounter rate and are not included in the cost statements or reports for rebasing.

(3) Rebasing will occur biennially during odd years for all established FQHCs and RHCs. The following documentation is required for rebasing each FQHC and RHC:

(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. For clinics that have certified audits must submit copy to OMAP. For clinics that receive more than \$250,000 a year in Medicaid funds must submit certified audit;

(e) Depreciation schedules;

(f) Overhead cost allocation schedules, and;

(g) A list of all clinic provider numbers and any other provider numbers associated with the FQHC or RHC. See OAR 410-147-0340 for details.

(4) Rebasing may also occur on a case-by-case basis. The following are general categories that may warrant rebasing at other intervals if the detailed documentation submitted to OMAP supports the need to rebase:

(a) The FQHC or RHC has a change in status. The clinic must submit a copy of the grant award or certification documents designating the status change;

(b) The FQHC or RHC has a change in the scope of services the clinic provides. Submit a copy of all documents showing change;

(c) The FQHC or RHC has a change in the geographic scope of services the clinic provides. Submit a copy of all documents showing the change.

(5) The Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs is due 90 days after the end of the clinic's fiscal year biennially during odd years.

(6) Clinics may submit cost reports anytime during the 90 day period after the clinic's FYE. The cost report would contain data for the previous fiscal year. Note: The rebased encounter rate does not become effective until the clinic accepts the rebase agreement.

(7) If there is a change of ownership, or withdrawal from the program the clinic has 30 days after the change or withdrawal to file a Cost Report (OMAP 3027) or Medicare Cost Reports for RHCs. A 30 day extension may be granted for good cause if a written request is received and approved in writing by OMAP prior to the expiration of the original 30 days.

(8) No revisions may be made to the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs after the original submission period without prior approval from OMAP.

(9) OMAP's ability to determine encounter rates is dependent on accurate and properly completed Cost Statements (OMAP 3027) or Medicare Cost Reports for RHCs. If the documentation is improperly

completed or incomplete this will delay the effective date of the new encounter rate. There are no retroactive effective dates or settlements for new encounter rates.

(10) The rate per encounter for FQHCs and RHCs will be established from actual costs for the preceding one fiscal year as provided in the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs and the audited financial statement.

(11) An improperly completed or incomplete Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs will be returned to the facility for proper completion, and must be returned to OMAP within 30 days of receipt. The Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs will be considered incomplete if all the required documents are not provided when submitted.

(12) Each required Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs must be signed by the authorized individual who normally signs the federal income tax return or similar report. If the Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs is prepared by someone other than an employee of the clinic, the preparer must also sign and indicate his or her status with the clinic.

(13) Change of scope is defined as the addition or loss of a specialty such as dental or mental health or the addition or loss of a clinic site. If the clinic's scope changes prior to rebasing the clinic's current encounter rate is to be used for all services including services within the clinic's new scope.

(14) Clinics may not request additional rebasing more than once per the clinic's FYE.

(15) OMAP retains the right to request financial documents at anytime for the purpose of adjusting the encounter rate if, OMAP has reason to believe that the clinic has:

(a) Substantially increased or decreased the scope of services or sites;

(b) Determined that the costs provided when establishing the encounter rate were inflated, OMAP may request a corrected Cost Statement (OMAP 3027) or Medicare Cost Report for RHCs and any other financial documents in order to review and adjust the encounter rate.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

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

Hist.: OMAP 63-2002, f. & cert. ef. 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 for each claim;

(b) To OMAP:

(A) Total payments for all services including lab and x-ray received from the MCO excluding any bonus or incentive payments.

(B) The total number of actual encounters, excluding all lab or x-ray 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.

(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 guide for the timelines schedule.

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

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

(5) 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.

(6) 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

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

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 allowable cost per encounter as defined in the FQHC and RHC guide. The Cost Statement (OMAP 3027) must be submitted to OMAP:

(a) For established clinics during the assigned rebasing schedule;

(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 the 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 the totals from each column under Allowable Overhead Costs on line 48;

(h) Enter the 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 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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0400

410-147-0500 Total Encounters for Cost Reports

(1) Each Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) is required to report total encounters as defined in the Bureau of Primary Health Care's Uniform Data System Manual, Definitions. All encounters which meet this definition including encounters for clients who are enrolled in a managed care organization, except for section (2) of this rule, must be included in total encounters as reported on the required financial documents shown in OAR 410-147-0320 and 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 outreach 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, 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 (described in OAR 410-147-0300) are included for both the total number of encounters as well as the total number of Medical

Assistance Program encounters in the required financial documents shown in OAR 410-147-0320.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0380

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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0260

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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0280

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

Hist.: HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0395

410-147-0580 General Billing and Payment Information

(1) Health Insurance Claim form (CMS-1500):

(a) The Office of Medical Assistance Programs (OMAP) requires you to use the Health Insurance Claim Form (CMS-1500) to bill for Medical Assistance Program services unless you are a pharmacy provider (use the Prescription Drug Invoice form, OMAP 502 or 502N);

(b) OMAP does not supply CMS-1500 forms. You can obtain them through local business forms suppliers or the Oregon Medical Association;

(c) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are eligible for reimbursement of professional services listed in the FQHC and RHC guide. These services are to be billed on a CMS-1500 using diagnoses that meet national coding standards, the appropriate encounter code, and type of service "1";

(d) Each CMS-1500 is a complete billing document. If there is not enough space on one CMS-1500 to include all procedures provided, continue on a new billing form, totalling each separately. Do not "carry over" totals from one CMS-1500 to another;

(e) Use a separate CMS-1500 for each client;

(f) Send all completed CMS-1500 forms to OMAP.

(2) Electronic Media Claims: OMAP accepts claims electronically. For more information, contact OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0030; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0280

410-147-0600 Instructions on Completing the CMS-1500

(1) Check your claim for missing or incorrect information before it's mailed. Your payment depends upon how well your claim is completed.

(2) How to Complete the CMS-1500:

(a) 1a -- The eight-digit recipient ID number found on the Office of Medical Assistance Programs (OMAP) Medical Care ID;

(b) 2 -- The client's name as it is printed on the OMAP Medical Care ID;

(c) 9 (required when applicable) -- If the client has other health insurance coverage as listed on the OMAP Medical Care ID, and no payment was received from that resource, this space must be used to explain why no payment was made. Select a two-digit "reason" code from the Third Party Resource (TPR) codes in the Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the TPR. For "reason" code NC, Not Covered, enter: NC-Blue Cross;

(d) 10 (required when applicable) -- Complete only when an injury is involved;

(e) 10d -- Enter a "Y" in this field if the service was an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency;

(f) 17-17a -- This information is required if your client has a Primary Care Case Manager (PCCM);

(g) 21 -- Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number. Enter up to four diagnosis codes in priority order. Carry the codes out to their highest degree of specificity (fourth or fifth digit). For multiple encounters on same date of service, refer to the FQHC and RHC guide for instructions;

(h) 24A -- Must be numeric. If "From-To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(i) 24B -- Enter the appropriate code for the place service was provided:

(A) 1 -- Inpatient Hospital;

(B) 2 -- Outpatient Hospital/Outpatient Department;

(C) 3 -- Practitioner's Office;

(D) 4 -- Client's Home, or school site, etc.;

(E) 5 -- Day Care Facility;

(F) 6 -- Night Care Facility;

(G) 7 -- Intermediate Care Facility;

(H) 8 -- Skilled Nursing Facility;

(I) A -- Independent Lab;

(J) B -- Other Medical/Surgical Facility;

(K) C -- Residential Treatment Center;

(L) D -- Specialized Treatment Center.

(j) 24C -- Enter type of service "1" unless otherwise specified in rules;

(k) 24D -- Enter the most appropriate code as described in the FQHC and RHC guide;

(l) 24E -- Enter the one-digit line number which refers to the primary diagnosis from Field 21 for each service billed;

(m) 24F -- Enter the charge for the service listed on that line;

(n) 24G -- Enter the number of days or units. This number must match the number of days in Field 24A;

(o) 24H -- Enter a "Y" if the service is related to family planning;

(p) 26 (optional) -- Enter your unique patient account number here. It will be printed on your Remittance Advice (RA). This area can also be used to identify the clinic site. This field can accommodate up to 12 characters;

(q) 28 -- Enter the total of all of the charges listed in Field 24F;

(r) 29 -- Enter the total amount paid by any other insurance or resource. Do not include OMAP copayments in this field. Do not show any payment from OMAP on this line. If the client has other insurance and this amount is zero, there must be a two-digit "reason" code in Field 9;

(s) 30 -- Enter the amount due after subtracting the Amount Paid from the Total Charge. Do not include insurance write-off amounts;

(t) 33 -- Enter your OMAP provider number here.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0700; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0300; OMAP 90-2002, f. 12-24-02, cert. ef. 1-1-03

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

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0040