DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Federally Qualified Health Centers and Rural Health Clinics

Rulebook

Includes:

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DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

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Update Information

for

July 1, 2007

DMAP updated the Rulebook with the following administrative rule adoption and other amendments:

DMAP adopted 410-147-0362 as DMAP is required by 42 USC § 1396a(bb)(3)(B), to adjust Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) Prospective Payment System (PPS) encounter rates based on any increase or decrease in the scope of FQHC or RHC services, as defined by 42 USC §§ 1396d(a)(2)(B-C). The Centers for Medicare and Medicaid Services (CMS) defines a “change in scope of services” as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS’ broad definition of change in scope of services allows DMAP the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to “type,” “intensity,” and “duration” and procedures for implementing these adjustments. This new rule states the DMAP criteria for change in scope of service requests, and the policy for implementing FQHC and RHC PPS rate adjustments based on DMAP-approved change-in-scope of services.

DMAP amended rules 410-147-0040 and 410-147-0500 to clarify current policies and procedures for FQHC and RHC providers to ensure Oregon Administrative Rules (OARs) are not open to interpretation by the provider or outside parties and will help eliminate confusion possibly resulting in non-compliance.

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

Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Federally Qualified Health Center and Rural Health Clinic (FQHC/RHC) Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Billing instructions
- ✓ Electronic claims information
- ✓ Vaccines for Children program information
- ✓ Biling for Medicare-Medicaid and QMB-only clients
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the FQHC/RHC Services Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/fqhc-rhc/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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410-147-0000 Foreword

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

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

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

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

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

(6) 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 DMAP.

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

(8) 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
1-1-07

410-147-0020 Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 Division 147), General Rules (OAR 410 Division 120), OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) Clinics must bill all services provided using diagnoses that meet national coding standards unless otherwise directed in Oregon Administrative Rule.

(4) Primary Care Manager (PCM) case management services, as defined in OHP Administrative Rules (OAR 410-141-0700) and previously provided under a PCM contract with Division of Medical Assistance Programs (DMAP), are included in the above listing of professional services.

(a) Clinics cannot bill DMAP for PCM case management services for coordinating medical care for a client as a stand-alone service since PCM case

management is included in a clinic's all-inclusive Prospective Payment System (PPS) encounter rate;

(b) Clinics will report case management services as an allowed administrative program cost on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

(5) Clinics cannot bill sign language and oral interpreter services as a stand-alone service since they are professional services included in a clinic's all-inclusive PPS encounter rate. Clinics must report this service as an allowed administrative program cost on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

(6) Clinics cannot bill supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job readiness as stand-alone services. These services are included in a clinic's all-inclusive PPS encounter rate. Clinics will report these services as allowed administrative program costs on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0040 ICD-9-CM Diagnosis and CPT/HCPCs Procedure 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) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis 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. Clinics may list up to three additional diagnosis codes 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) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-9-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for calendar years 2006 and 2007 for the date the service(s) was provided:

(a) Use codes on Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) Use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) for physician services and other health care services. These services include, but are not limited to, the following:

(A) Physician services;

(B) Physical and occupational therapy services;

(C) Radiology procedures;

(D) Clinical laboratory tests;

(E) Other medical diagnostic procedures;

(F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death With Dignity services. Refer to OAR 410 Division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services, for specific requirements.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-07

410-147-0060 Prior Authorization

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clients who are not enrolled in a PHP, receive services on an "open card" or "fee-for-service" (FFS) basis. The current month's Medical Care Identification specifies the client's status.

(2) Prior Authorization (PA) is not required for covered services provided within a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to a "fee-for-service" client, with the exception of pharmacy services and hospital dentistry. Refer to OAR 410-147-0280 Drugs, OAR 410 Division 121 Pharmaceutical Services and OAR 410 Division 125, Hospital Services.

(3) Clients who are enrolled in a PHP 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 PHP 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 a PHP, and the PHP denies payment, the Division of Medical Assistance Programs (DMAP) will reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the FQHC or RHC's responsibility to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP Client enrolled in a PHP. The FQHC or RHC needs to contact the client's PHP for specific instructions.

(5) If a client receives services on "fee-for-service" basis, a PA may be required for certain services. An FQHC or RHC assumes full financial risk in providing services to a "fee-for-service" client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). Some covered

services or items require authorization by DMAP before the service can be provided or before payment will be made. See OAR 410-120-1320 Authorization of Payment.

(6) If the service or item is subject to Prior Authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0080 Prepaid Health Plans (PHPs)

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clinics serving eligible OHP clients who are enrolled in a PHP must secure authorization from the PHP prior to providing PHP-covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral from the PHP before providing any services to clients enrolled in a PHP unless the FQHC or RHC have contracted with the PHP to provide PHP-covered services. If an FQHC or RHC has an arrangement or contract with a PHP, the clinic is responsible to follow PHP rules and prior authorization requirements. See OAR 410 Division 141 for OHP Program Rules and; OAR 410-147-0060, Prior Authorization.

(2) The Division of Medical Assistance Programs (DMAP) encourages FQHCs and RHCs to contact each PHP in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) PHPs contracting with FQHCs or RHCs, for the provision of providing services to their clients, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP would make for services furnished by a non-FQHC/RHC provider.

(4) Payment for services provided to PHP-enrolled clients is a matter between the FQHC or RHC and the PHP authorizing the services except as otherwise provided in OAR 410-141-0410, OHP Primary Care Managers. If a PHP denies payment to an FQHC or RHC because arrangements were not made with the PHP prior to providing the service, DMAP will not reimburse the FQHC or RHC under the encounter rate, except as outlined in Section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).

(5) FQHCs and RHCs can provide family planning services or HIV/AIDS prevention services to eligible OHP clients enrolled in PHPs without authorization or a referral from the PHP. The FQHC and RHC must bill the PHP first. If the PHP will not reimburse for the service, then the clinic may bill DMAP. Refer to ORS 414.153, Authorization for payment for certain point of contact services.

(6) PHPs will execute agreements with publicly funded providers, unless cause can be demonstrated to the DMAP satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(7) PHPs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical, mental health or dental care visits, for their enrolled DMAP Members with a hearing impairment or who are non-English speaking. Services must be sufficient for the FQHC or RHC provider to be able to understand the DMAP Member's complaint; to make a diagnosis; respond to the DMAP Member's questions and concerns; and to communicate instructions to the DMAP Member. See OAR 410-141-0220(7), Oregon Health Plan Prepaid Health Plan Accessibility.

(8) The Provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. (See OAR 410-120-1140). It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided;

(b) Whether a client receives services on a fee-for-service (open card) basis or is enrolled with a PHP; and

(c) Whether the service is covered by a third party resource (TPR), a PHP, or if DMAP reimburses on a fee-for-service basis.

(9) DMAP requires the following of a FQHC or RHC under contract with a PHP:

(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Record Keeping, a PHP’s participating providers shall maintain a clinical record

keeping system with sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the DMAP Member. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;

(b) Clinics are subject to ongoing performance review by the PHP. According to OAR 410-141-0200, Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System, PHPs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to DMAP Members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(c) Clinics are subject to program review by DMAP, the Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:

(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;

(B) Accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, is used for calculating PHP supplemental payments and compensation for out-stationed outreach workers;

(C) Adequate records are maintained for cost reimbursed services to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0085 Client Copayments

(1) The Division of Medical Assistance Programs (DMAP) Medical Care Identification will indicate which Oregon Health Plan (OHP) clients are responsible for copayments for services.

(2) DMAP requires copayments from clients with certain benefit packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.

(3) A client may owe more than one copayment during a 24-hour period. DMAP may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0120 DMAP Encounter and Recognized Practitioners

(1) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounters billed to the Division of Medical Assistance Programs (DMAP) must meet the definition in Sections (2) and (3) of this rule and are limited to DMAP Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. An encounter includes all services, items and supplies provided to a client during the course of an office visit except as excluded in Section (11) of this rule. Section (3) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation. See also OAR 410-120-1200(2)(y). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(4) Encounters with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, refer to OAR 410-147-0140 for reporting multiple encounters.

(5) Refer to Table 147-0120-1 for a list of procedure codes used to report encounters when billing DMAP directly for non-PHP-enrolled, or open card, clients. DMAP will reimburse a clinic at their all-inclusive Prospective Payment System (PPS) encounter rate for the following services when billed as an encounter and include any related medical supplies provided during the course of the encounter. (Refer to individual program administrative rules for service limitations.):

(a) Medical (OAR 410 Division 130);

(b) Diagnostic: DMAP covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, DMAP will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-147-0220);

(d) Dental - Refer to OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123;

(e) Vision (OAR 410 Division 140);

(f) Physical Therapy (OAR 410 Division 131);

(g) Occupational Therapy (OAR 410 Division 131);

(h) Podiatry (OAR 410 Division 130);

(i) Mental Health (OAR 309 Division 16);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 415 Divisions 50 and 51). Requires a letter or licensure of approval by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(k) Maternity Case Management (OAR 410-147-0200);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) DMAP considers a home visit for assessment, diagnosis, treatment or Maternity Case Management (MCM) as an encounter. DMAP does not consider home visits for MCM as Home Health Services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and DMAP Administrative Rules.

(6) The following practitioners are recognized by DMAP:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) -- may provide dental hygiene services without the supervision of a dentist in certain settings. See the section on Limited Access Permits, ORS 680.200 and OAR 818-035-0065 through OAR 818-035-0100 for more information;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses -- may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by DMAP in this section and who is authorized to independently diagnose and treat according to OAR 851 Division 45);

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists (refer to OAR 410 Division 130 for service coverage and limitations); and

(n) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(i) Their individual provider's certification or license; or

(ii) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320(3) and (5).

(7) The clinic must not bill for drugs or medication treatments provided during a clinic visit since they are part of the encounter rate. For example, a hypertensive drug or drug sample dispensed by a clinic to treat a client with high blood pressure during an office visit is included in the all-inclusive encounter rate.

(8) DMAP considers medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) used during an office visit to be part of the cost of an encounter. Clinics cannot bill these items separately as fee-for-service charges;

(9) Clinics cannot bill Primary Care Manager (PCM) case management services for coordinating medical care for a client separately as fee-for-service since such services are included in the cost of an encounter. See also OAR 410-147-0020(4), Professional Services.

(10) 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 42 § 405.2417), and any other ambulatory services covered by DMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(11) DMAP excludes the following from the definition of an FQHC or RHC encounter:

(a) Laboratory and/or radiology services as stand alone services are not considered a valid clinic encounter. These services are secondary or resulting from the office visit encounter and are therefore included in the originating encounter and cannot be billed separately;

(b) Clinics cannot bill separately for venipuncture for lab tests since it is part of the encounter. DMAP does not deem a visit for lab test only to be a clinic encounter;

(c) Durable medical equipment or medical supplies (e.g. diabetic supplies) not generally provided during the course of a clinic visit.

(d) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program. Clinics cannot bill DMAP or the PHP for samples provided at no cost to the clinic. Prescriptions are not included in the encounter rate and qualified enrolled pharmacy providers must bill DMAP through the pharmacy. Refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(e) Administrative medical examinations and report services (See OAR 410 Division 150);

(f) Death with Dignity services (See OAR 410-130-0670);

(g) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients. (See OAR 410-120-1210, OAR 461-135-1070 and OAR 410-130-0240);

(h) Services provided to Qualified Medicare Beneficiary (QMB) only clients. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information is located in the FQHC and RHC Supplemental Information billing guide;

(i) Targeted Case Management (TCM) services (See OAR 410 Division 138); and

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

(12) OAR 410-120-1210 describes the OHP benefit packages and delivery system. Most OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or

"fee-for-service" (FFS) basis. The current month's Medical Care Identification specifies the client's status.

(a) DMAP is responsible for making payment for services provided to open card clients. The provider will bill DMAP the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package. Refer to 410-147-0360, Encounter Rate Determination.

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their DMAP members. Refer to OAR 410-120-0250, and OAR 410 Division 141, OHP Administrative Rules governing PHPs. The provider must bill the PHP directly for services provided to an enrolled client. See also OAR 410-147-0080, Prepaid Health Plans, and OAR 410-147-0460, PHP Supplemental Payment. Clinics must not bill DMAP an encounter for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(i) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(ii) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(13) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances DMAP will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing DMAP. For the purposes of this rule "reasonable efforts" include, but are not limited to:

(a) Asking the client if they have coverage from Medicare, private insurance or another resource;

(b) Using an insurance database such as Electronic Eligibility Verification Services (EEVS) available to the Provider; or

(c) Verifying the client's insurance coverage through the Automated Information System (AIS) or the Medical Care Identification on each date of service and at the time of billing.

(14) When a Provider receives a payment from any source prior to the submission of a claim to DMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See OARs 410-120-1280 Billing and 410-120-1340 Payment.

(15) Codes for encounters: Due to the unique billing and payment methodology, and the implementation of the Health Insurance Portability and Accountability Act (HIPAA), DMAP selected specific CPT and HCPCS codes for clinics to report encounters. Providers must bill DMAP with the procedure codes indicated in Table 147-0120-1 for FQHC and RHC services eligible for reimbursement per a clinic's encounter rate. For services that are not included in the all-inclusive encounter rate, refer to the appropriate DMAP provider rules for billing instructions.

(16) 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. See also Section (5)(b) of this rule.

Table 147-0120-1

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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

Effective July 1, 2006

FQHCs/RHCs are limited to the procedure codes listed in this Table when billing DMAP directly for open card, "fee-for-service," clients for services that are included in the encounter rate. Codes used as an encounter represent all service provided to a client on the same date of service. The modifiers listed are required when appropriate. FQHCs/RHCs are not limited to the procedure codes listed in this Table when billing a Managed Care Organization (MCO), Medicare, or any other Third Party Resource (TPR).

When billing for a clinic visit for an DMAP-covered service and the procedure code is not listed in this table, a clinic must select the most appropriate CPT or HCPC procedure code from this table to be reimbursed at the clinic's encounter rate.

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

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

Routine Medical Office Visits: • 99201-99317 • 99319-99338 • 99341-99350 • 99372 or • 99381-99440	Immunization Administration: • 90471 **Only use 90471 if administration of an immunization is the sole purpose of the clinic visit. Use modifier SL or SK as appropriate.**	Tobacco Cessation: • S9075 or • G9016 **Only use if it is the sole reason for the visit. Cannot be billed as a multiple encounter.** Refer to OAR 410-147-0220
Maternity Case Management (MCM): • G9012 **HCPCS G9012 is used for all MCM services** Refer to OAR 410-147-0200	Antepartum, Postpartum Visits or Prenatal Care: • 99201-99317 • 99319-99338 • 99372 or • 99381-99440	Delivery Services: • 59409 • 59514 • 59612 or • 59620

	Addiction Services: • H0001-H0002 • H0004-H0005 • T1006	Outpatient Mental Health: • 90801-90815 • 90847-90857 • 90862 (only if sole reason for visit) **A medical visit with a mental health diagnosis may not be billed on the same date of service as a mental health visit.**
	Dental Prophylaxis: • D1110-D1202 **Only use this procedure code if it is the sole reason for the dental visit.** Refer to OAR 410 Division 123	Dental Exams: • D0120-D0180 Refer to OAR 410 Division 123
Opthalmological Services: (**Excluding exams for the purpose of prescribing glasses or contacts**) • 92002-92014 Refer to OAR 410 Division 140	Eye Exams: **(Prescription of glasses or contacts)** • S0620-S0621 **Fitting, dispensing and repair is included in the encounter rate paid at the time of the exam. All glasses or contacts must be purchased through DMAPs Vision Supply Contract**. Refer to OAR 410 Division 140	Physical & Occupational Therapy: • 97001-97004 Refer to OAR 410 Division 131

Medical/Surgical/Dental Treatment or Service: HCPCS T1015 is used when a treatment or procedure is provided and no other procedure code listed in this table appropriately describes the service. Refer to OAR 410 Division 130 (Med/Surg), OAR 410-147-0125, and OAR 410 Division 123 (Dental)	The following conditions require the use of a modifier for all codes: Family Planning Service - FP 410-130-0585 Family Planning Services Vaccine for Children - SL Refer to OAR 410-130-0255(4) Immunization for High Risk - SK Medicaid EPDST Services - EP Refer to OAR 410-130-0245 The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program	T1015 is a nationally recognized HCPCS code that denotes a per diem encounter rate, and requires the use of a modifier: For antepartum, postpartum or prenatal visits not described otherwise in this document use modifier TH. For family planning services use modifier FP. All other services use modifier SU.

410-147-0125 OHP Standard Emergency Dental Benefit

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Refer to OAR 410-123-1670 OHP Standard Limited Emergency Dental Benefit.

(2) Services are limited to those procedures listed in OAR 410-123-1670, Table 123-1670-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) An FQHC billing Division of Medical Assistance Programs (DMAP) directly for dental services provided to an open card OHP Standard client, must bill the covered service(s) in accordance with Section (2) of this rule, using a dental procedure code as listed in Table 147-0120-1, FQHC/RHC encounter codes.

(4) An FQHC is not limited to the FQHC/RHC encounter procedure codes listed in Table 147-0120-1 when billing a Dental Care Organization (DCO), Medicare, or any other Third Party Resource (TPR).

(5) Hospital Dentistry is not a covered benefit for the OHP Standard population except for covered services authorized in accordance with Section (2) of this rule when provided to:

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

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

(6) Any limitations or prior authorization requirements for services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0140 Multiple Encounters

(1) An encounter is defined in OAR 410-147-0120.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (Refer to OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (Section (4) of this rule, and OAR 410 Division 130);

(b) Dental (OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123);

(c) Mental Health (OAR 309 Division 016). If a client is also seen for a medical office visit and receives a mental health diagnosis, then providers must report only one encounter;

(d) Addiction and Alcohol and Chemical Dependency (OAR 415 Divisions 50 and 51). If a client is also seen for a medical office visit and receives an addiction diagnosis, then providers must report only one encounter;

(e) Ophthalmologic services - fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR 410 Division 140);

(f) Maternity Case Management MCM (OAR 410-147-0200);

(g) Physical or occupational therapy (PT/OT) - If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR 410 Division 131); and

(h) Immunizations – if no other medical office visit occurs on the same date of service.

(3) Division of Medical Assistance Programs (DMAP) expects that multiple encounters will occur on an infrequent basis.

(4) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first Medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in Section (2) of this rule.

(5) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

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

(a) A well child check and an immunization;

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

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist;

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

(7) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by DMAP, and/or contracts with the recipient's PHP, if the FQHC/RHC is not the recipient's primary care manager.

(8) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

1-1-07

410-147-0160 Modifiers

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

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

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in their individual program Administrative Rules.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients. Costs associated with vaccines are included in the definition of an encounter and are not billed separately to DMAP.

(2) The VFC program supplies federally purchased free vaccines for immunizing eligible clients ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Department of Human Services Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0200 Maternity Case Management Services

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Maternity Case Management (MCM) services. Refer to OAR 410-147-0120 Encounter, and Table 147-0120-1.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill DMAP directly per the clinic's PPS encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management (MCM) for specific requirements.

(4) 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.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day cannot be billed as multiple encounters.

(6) A medical encounter and an MCM encounter can occur on the same day only under the following two circumstances:

(a) The practitioner can bill a prenatal visit and a MCM service on the same day as separate encounters only if the MCM service is the initial evaluation visit;

(b) After the initial evaluation visit, the practitioner can bill the nutritional counseling MCM service if provided on the same day as a prenatal visit as two separate encounters. See Section (7)(c) of this rule for limitations.

(7) MCM Services limitations:

(a) DMAP reimburses the initial evaluation one time per pregnancy per provider;

(b) Providers may bill DMAP for case management visits four times per pregnancy. In addition, if a client is identified as high risk; the practitioner may bill six additional case management visits;

(c) DMAP reimburses Nutritional Counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(d) DMAP reimburses a Home/Environmental Assessment one time per pregnancy, and is included in the total number of case management visits in Section (7)(b) of this rule.

(8) A client may only participate in a single case management program. DMAP does not allow multiple case management billings. This includes Maternity Case Management (MCM), and any Targeted Case Management (TCM) Program outlined in OAR 410 Division 138.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 1-1-07

410-147-0220 Tobacco Cessation

(1) The Division of Medical Assistance Programs(DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for tobacco cessation services under the encounter rate. Bill procedure codes G9016 for tobacco cessation counseling and S9075 for tobacco cessation treatment, with diagnosis code 305.1 (Tobacco Use Disorder). Refer to Table 147-0120-1.

(2) Refer to OAR 410-130-0190 for specific requirements and treatment limitations.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0240 Administrative Medical Examinations and Reports

(1) The Division of Medical Assistance Programs (DMAP) does not reimburse Administrative Medical Examinations and Reports at a clinic's encounter rate. DMAP reimburses providers for Administrative Examinations and Reports on a fee-for-service basis.

(2) Refer to OAR 410 Division 150, Administrative Examination and Billing Services, for specific requirements. See Administrative Exams Supplemental Information for more detailed information on procedure codes and descriptions.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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 Division of Medical Assistance Programs (DMAP), 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
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1-1-07

410-147-0280 Drugs

(1) The Division of Medical Assistance Programs(DMAP) excludes pharmaceutical or biologicals not generally provided during a clinic visit from the definition of an FQHC or RHC encounter.

(a) Providers cannot bill separately for drugs or medication treatments dispensed by a clinic to treat a client during an office visit since DMAP includes them in the all-inclusive encounter rate for the office visit;

(b) Prescriptions are not included in the encounter rate and a qualified enrolled pharmacy must bill DMAP through the pharmacy program.

(2) Clinics may directly bill DMAP only for contraceptive supplies and contraceptive medications outside of the pharmacy program:

(a) Clinics must bill the Prepaid Health Plan (PHP) first for clients enrolled in a PHP. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill DMAP fee-for-service at the clinic's acquisition cost. See also OAR 410-130-0585, Family Planning Services;

(b) Clinics can directly bill DMAP fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications dispensed by a clinic to a non-PHP-enrolled client. See also OAR 410-130-0585, Family Planning Services.

(3) Refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 409

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1-1-07

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

(1) This rule outlines the Division of Medical Assistance Programs (DMAP) enrollment requirements for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Refer also to OAR 410-120-1260 Provider Enrollment.

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians, providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR 410 Division 146, for enrollment details;

(b) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. Refer to OAR 410 Division 121, Pharmaceutical; OAR 410 Division 122, DMEPOS; and OAR 410 Division 138, TCM for specific information.

(2) To enroll with DMAP as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330;

(b) Have received FQHC Look-Alike designation from the Centers for Medicare and Medicaid Services (CMS), based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC).

(3) Eligible FQHCs who want to enroll with DMAP as an FQHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DMAP Provider Application Form 3117 for an Agency;

(b) Completed Cost Statement(s) (DMAP 3027):

(i) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency). See also OAR 410-147-0360;

(ii) Complete a cost statement for each FQHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers;

(c) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(d) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(e) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports;

(f) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations";

(g) Depreciation schedules;

(h) Overhead cost allocation schedule;

(i) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through OAR 309-012-0220, Certificates of Approval for Mental Health Services; OAR 309-032-0525 through OAR 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through OAR 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through OAR 309-039-0580, Standards for the

Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(j) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(k) A list of all Prepaid Health Plan (PHP) contracts;

(l) A list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the FQHC; and

(m) A list of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status along with all DMAP provider numbers assigned to these clinics.

(4) For enrollment with DMAP as an RHC, a clinic must:

(a) Be designated by CMS as an RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with DMAP as an RHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DMAP Provider Application Form 3117 for an Agency;

(b) Copy of Medicare's letter certifying the clinic as an RHC;

(c) Medicare Cost Report for RHC or completed Cost Statement(s) (DMAP 3027). See also OAR 410-147-0360. Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(d) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports (only if completing Cost Statement DMAP 3027);

(e) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" (only if completing Cost Statement DMAP 3027);

(f) Depreciation schedules (only if completing Cost Statement DMAP 3027);

(g) Overhead cost allocation schedules (only if completing Cost Statement DMAP 3027);

(h) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through OAR 309-012-0220, Certificates of Approval for Mental Health Services; OAR 309-032-0525 through OAR 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through OAR 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through OAR 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(i) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(j) A list of all Prepaid Health Plan (PHP) contracts;

(k) A list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the RHC; and

(l) A list of all clinics affiliated or owned by the RHC including any clinics that do not have RHC status along with all DMAP provider numbers assigned to these clinics.

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in Section (3) of this rule for FQHCs and Section (5) of this rule for RHCs, will review all documents for compliance with program rules, completeness and accuracy.

(7) DMAP prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC DMAP provider number, and according to the PPS encounter rate, prior to DMAP's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, DMAP:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an RHC;

(c) A recent list of all Prepaid Health Plan (PHP) contracts; and

(d) A recent list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership;

(b) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit all rights to calculation of a PPS encounter rate(s) at a later date. The PPS

encounter rate(s) calculated under the former ownership will in effect be reassigned to the new ownership;

(c) Notice of a change in tax identification number;

(d) A recent list of all Prepaid Health Plan (PHP) contracts;

(e) A recent list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the FQHC or RHC; and

(f) A recent list of all clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status along with all DMAP provider numbers assigned to these clinics.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

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

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

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

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

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

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

(a) A billing provider number; and

(b) Performing provider numbers for each practitioner.

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

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

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

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

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

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

Stat. Auth.: ORS 409

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1-1-07

410-147-0360 Encounter Rate Determination

(1) The Division of Medical Assistance Programs (DMAP) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) DMAP will enroll a clinic as an FQHC or RHC effective the date DMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with DMAP and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to DMAP for providing specific care, item(s), or service(s) to DMAP clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with DMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health (including Addiction, Alcohol and Chemical Dependency) Services.

(a) Effective October 1, 2004, for FQHCs only, DMAP will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with DMAP:

(i) Medical;

(ii) Dental; and

(iii) Mental Health, to include addiction, alcohol and chemical dependency services.

(b) FQHCs enrolled with DMAP prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate

calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) DMAP will accept an uncertified Medicare Cost Report;

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

(c) DMAP will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit theDMAP cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by DMAP. If exempted from this requirement by DMAP, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. DMAP does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving DMAP clients when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include

financial documents for Medicaid-covered services provided at clinic sites that see DMAP clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve DMAP clients in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if DMAP determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, DMAP may:

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

(b) Impose sanctions as defined in OARs 410-147-0560 and 410-120-1400.

(9) Effective January 1, 2001, DMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with DMAP as a FQHC or RHC as of January 1, 2001, receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC.

Coinciding with enrollment as an FQHC or RHC with DMAP, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by DMAP to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;

(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to DMAP for review.

(15) DMAP may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health (including addiction, and alcohol and chemical dependency) services. A separate PPS encounter rate will be calculated by DMAP for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Addictions and Mental Health Division (AMH) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by OMHAS to provide addiction, and alcohol and chemical dependency services;

(i) Certification by OMHAS of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by OMHAS is required for FQHCs providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health (including addiction, and alcohol and chemical dependency) services, after the initial encounter rate determination, DMAP will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

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

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

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1-1-07

410-147-0362 Change in Scope of Services

(1) As required by 42 USC § 1396a(bb)(3)(B), the Division of Medical Assistance Programs (DMAP) must adjust Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) Prospective Payment System (PPS) encounter rates based on any increase or decrease in the scope of FQHC or RHC services, as defined by 42 USC §§ 1396d(a)(2)(B-C).

(2) The Centers for Medicare and Medicaid Services (CMS) defines a "change in scope of services" as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS' broad definition of change in scope of services allows DMAP the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements "type," "intensity," "duration," and "amount" and procedures for implementing these adjustments. This rule defines the DMAP policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

(3) A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC §§ 1396d(a)(2)(B-C).

(4) A change in the cost of a service is not considered in and of itself a change in the scope of services. A FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers' services.

(5) The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

(A) Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

(B) Services that do not require a face-to-face visit with a FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case-management, supportive rehabilitative services, and enabling services.)

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

(A) A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

(B) The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

(i) If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

(ii) If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

(c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center;

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

(e) A change in applicable technologies or medical practices:

(A) Maintaining Electronic Medical Records (EMR);

(B) Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

(C) Updating practice management systems;

(f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

(A) Changes in laws or regulations affecting health center malpractice insurance;

(B) Changes in laws or regulations affecting building safety requirements; or

(C) Changes in laws or regulations relating to patient privacy.

(6) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3)-(5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or (e) A change in the number of patients served.

(7) Threshold Change in Cost per Visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over

the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3) - (5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(8) If a FQHC or RHC has experienced an increase or decrease in the health center's scope of services, as described in sections (3)-(5) of this rule, and that meets the threshold requirement of section (7) of this rule, the FQHC or RHC must submit to DMAP a written application as outlined below. DMAP may also initiate a review of whether a change in scope of services has occurred at a health center:

(a) A written narrative describing the specific changes in health center services, and how these changes relate to a change in the health center's overall picture of services;

(b) An estimate of billable Medicaid encounters for the forthcoming 12-month period so the financial impact to DMAP can be accounted for;

(c) A cost statement. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found at 42 CFR 413, HCFA Publication 15-1 (Provider Reimbursement Manual), and any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principals (GAAP). See Change in Scope Cost Report Instructions;

(d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by nonlicensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and

(e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3)(j) and (5)(i); and

(f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.

(9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program Manager will:

(a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the DMAP review until the complete application is received; and

(b) Respond to the health center with a decision within 90 days of receipt of a complete application.

(10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) Approved Change in Scope of Service requests will result in PPS rate adjustments:

(a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;

(b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.

(12) The new rate will be effective beginning the first day of the quarter immediately following the date DMAP approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

(a) DMAP will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

(b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.

(13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:

(a) For anticipated changes, health centers should submit prospective costs for DMAP to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by DMAP. Health centers may later request a subsequent rate adjustment based on actual costs;

(b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;

(c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the DMAP FQHC/RHC Program Manager to confirm the appropriate time periods of costs to submit.

(14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

(A) The first year of actual costs beginning the date on which a change in the cost per visit threshold is met; or

(B) The calendar year or the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met;

(b) For changes that occurred over multiple and overlapping time periods, FQHC/RHCs will submit actual costs for the time period beginning when all changes were in effect. For example, if changes occurred in 2003 and 2004, health centers would submit their 2004 cost report that would include costs for changes implemented in both 2003 and 2004;

(c) Rate adjustments calculated using costs from prior fiscal years will be adjusted by the Medicare Economic Index (MEI) to present.

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7-1-07

410-147-0365 Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care Delivery Procedures

(1) A Medicare certified RHC, as defined below, may be eligible for an obstetrics (OB) alternate payment methodology (APM) encounter rate for delivery procedures. The OB APM delivery encounter rate includes additional OB delivery-related costs incurred by a clinic as a cost-based payment in addition to the Prospective Payment System (PPS) medical encounter rate. The OB APM is contingent, and becomes effective, upon federal approval of the State Plan Amendment. The intent of the OB APM is to maintain access to OB care, including delivery services, in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care, not to exceed 100% of reasonable cost.

(2) To be eligible for the OB APM delivery encounter rate, a Medicare certified RHC must meet all Division of Medical Assistance Programs (DMAP) requirements applicable to an RHC, qualify as either “frontier” or “remote rural” as defined in section (2)(a) and (b) of this rule, be located in a service area with unmet medical need defined in section (2)(c), and must request to participate in writing pursuant to participation requirements specified in sections (3) and (5).

(a) Frontier RHC is defined as located in a frontier county as designated by the Oregon Office of Rural Health;

(b) Remote rural RHC is defined as located in a remote rural service area as designated by the Oregon Office of Rural Health;

(c) A frontier or remote rural RHC must be located in a service area of unmet medical need as determined by the Oregon Office of Rural Health for the year in which the written request for OB APM was made.

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

(a) An eligible RHC must submit a written request to DMAP for the OB APM delivery encounter rate. The RHC is responsible for providing all documentation necessary for DMAP to conduct the calculations described

in this rule. Failure to provide necessary documentation with the request to participate may result in a delay of the calculation and effective date of the OB APM delivery encounter rate.

(b) RHCs that meet the requirements in section (2) of this rule prior to Federal approval of the State Plan Amendment (SPA) may bill, using the OB APM delivery encounter rate, effective the date of Federal approval of the SPA provided DMAP has determined the clinic's OB APM delivery encounter rate.

(c) RHCs that meet the requirements in section (2) of this rule after the Federal approval date of the SPA may bill, using the OB APM delivery encounter rate, effective the date DMAP determines the clinic's OB APM delivery encounter rate.

(4) Care status changes:

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

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

(A) If OB care access including delivery services in a community has changed;

(B) If the RHC no longer meets the requirements for the OB APM:

(i) An RHC's agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) is terminated, or

(ii) The location of an RHC does not qualify as an unmet medical need service area as determined by the Oregon Office of Rural Health for five consecutive years;

(C) The stability of new providers supplying additional OB care access including delivery services;

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

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

(5) Determining OB APM Delivery Encounter Rate: The frontier or remote rural RHC requesting an OB APM delivery encounter rate, and meeting the DMAP requirements, will have an OB APM delivery encounter rate which is the sum of a clinic's PPS medical encounter rate and an OB cost-based payment. The OB payment is calculated from costs uniquely associated with OB delivery services and which were not used in the calculation of a clinic's PPS medical encounter rate as outlined in the State Plan, Attachment 4.19B:

(a) Qualification of the OB APM delivery encounter rate is not considered a change of scope;

(b) The Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM delivery encounter rate once established;

(c) DMAP will use the information listed below to determine the eligible RHC's initial OB payment. With the written request for an OB APM delivery encounter rate, both an existing and new clinic must provide:

(A) Total number of delivery encounters;

(B) Malpractice premiums for all physicians and certified nurses performing OB deliveries for the current and next year; and

(C) On-call time coverage;

(d) Delivery encounters include vaginal and cesarean delivery professional services provided by the RHC:

(A) Clinics performing deliveries prior to written request for an OB APM delivery encounter rate must provide the most recent full year of claims data for deliveries; and

(B) Clinics that have not previously provided delivery services must provide a reasonable projection of delivery encounters for the forecasted year;

(C) Clinics with actual or projected delivery encounters less than 100, will have their OB payment calculated using a base number of 100 OB delivery encounters;

(e) DMAP will calculate an additional projected cost of malpractice (liability) premiums to be included in the OB cost-based payment, outside of costs included and which have already been accounted for in the PPS medical encounter rate, as follows:

(A) For both an existing and new clinic, DMAP will calculate malpractice premiums that are based on the average costs for the current and next year based on the date the clinic applies for the OB APM delivery encounter rate, as projected by the RHC's malpractice carrier. Costs are the premiums the clinic or individual actually pays, accounting for any reductions or credits;

(B) For existing clinics, DMAP will determine the malpractice premiums reported for physicians and certified nurses performing OB deliveries when the RHC initially enrolled with DMAP and the PPS medical encounter rate was calculated. Premium amounts used in the initial PPS medical encounter rate calculation will be adjusted by the MEI for each subsequent year of enrollment, up to the year of written request for an OB APM delivery encounter rate. The premium(s) adjusted by MEI is an amount included in the current PPS medical encounter rate;

(C) For new clinics, DMAP will determine the actual malpractice premiums for OB physicians and certified nurses performing OB deliveries for the current year;

(D) DMAP will subtract the premiums calculated in section (5)(e)(B) or (C) of this rule, and accounted for in the calculation of the clinic's PPS medical encounter rate, from the average cost of OB malpractice premiums in section (5)(e)(A), to calculate the projected portion of OB malpractice premiums to be included in calculating the OB payment;

(f) DMAP will calculate the cost of physician on-call time for OB care by multiplying a clinic's adjusted OB on-call hours of coverage by the fixed

rate of $20.00 per hour. A clinic's adjusted OB on-call coverage hours will be calculated as follows:

(A) Reducing total clinic coverage hours per year by the clinic's daily office hours, and;

(B) Reduced by physician vacation hours, and;

(C) Calculated at 60 percent of adjusted on-call time;

(g) The OB payment will be the sum of the difference of averaged malpractice premiums and current actual premiums in section (5)(e) of this rule, and the cost of on-call coverage in section (5)(f), divided by the total number of OB care delivery encounters in section (5)(d);

(h) The OB APM delivery encounter rate is the sum of the OB payment in section (5)(g) of this rule and the PPS medical encounter rate.

(6) After DMAP has calculated the initial OB APM delivery encounter rate DMAP will inform the RHC.

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1-1-07

410-147-0380 Accounting and Record Keeping

(1) General Requirements:

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

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

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

(d) Must adhere to acceptable accounting standards.

(2) Rules and Regulations:

(a) FQHC and RHC Administrative Rules;

(b) The Division of Medical Assistance Programs (DMAP) General Rules;

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

(d) All other applicable DMAP provider rules.

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

(4) Each FQHC and RHC shall:

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

(b) Maintain complete client documentation;

(c) Adequately safeguard from duplicate billings or other routine billing errors;

(d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;

(e) Prepare Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs in conformance with:

(A) Generally accepted accounting principles;

(B) The provisions of the FQHC and RHC Administrative Rules; and

(C) All other applicable rules listed in sections (2) and (3).

(f) Maintain for a period of not less than five years from the end of the fiscal the year:

(A) Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs;

(B) Cost Statement Worksheet (DMAP 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 (DMAP 3027) or Medicare Cost Report for RHCs.

(g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (DMAP 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

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

(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs for current or previous periods at the DMAP request. These work papers/reports must be completed within 30 days of the DMAP 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 (DMAP 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 DMAP may request. If the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by DMAP;

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

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

(B) Do not serve Medical Assistance Program clients.

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1-1-07

410-147-0400 Compensation for Outstationed Outreach Activities

(1) This rule provides reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices. Reasonable compensation may be provided to eligible Federally Qualified Health Centers (FQHCs) for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs:

(a) The Division of Medical Assistance Programs (DMAP) will calculate an OSOW rate based on reasonable direct costs described in Section (6) of this rule, and reported by a clinic per Section (3) of this rule;

(b) The OSOW rate will be added to the clinic's current base medical Prospective Payment System (PPS) encounter rate.

(2) An FQHC must have a current Outreach Agreement with the State of Oregon, Department of Human Services (DHS), DMAP to be eligible for compensation under this rule.

(3) Clinics must submit a cost statement for the preceding fiscal year no earlier than October 1, and no later than October 31, of each year to DMAP for review of the clinic's OSOW direct costs for approval before any OSOW compensation is added to the PPS encounter rate:

(a) Any change to the OSOW rate, based on the October cost statement submission, will be effective January 1st of the following year;

(b) If, it is determined that the OSOW rate is inflated, the clinics OSOW rate will be adjusted effective immediately.

(4) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percent of time spent performing OSOW services and maintain adequate documentation to support the percentage of time claimed. The percent must be used to calculate personnel expenses incurred by an FQHC as outlined in

Section (6)(c) of this rule and that are directly attributed to outreach activities performed by the employee.

(5) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in Section (6)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an outstation outreach worker will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(6) Direct cost expenses allowed for OSOW reimbursement:

(a) Travel expenses incurred by the FQHC for DMAP training on OSOW activities;

(b) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(c) Personnel costs for OSOWs:

(A) Wages;

(B) Taxes;

(C) Fringe Benefits provided to OSOW;

(D) Premiums paid by the FQHC for Private Health Insurance.

(d) Reasonable equipment necessary to perform outreach activities. Do not include expenses for replacing equipment if the original cost of

the equipment was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs. Do not include rent or space costs if 100% of facility costs were reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(7) DMAP excludes indirect costs relating to OSOW activities from calculation of the OSOW rate. Excluded indirect costs include and are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's Prospective Payment System (PPS) encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs; and

(d) Operating expenses including utilities, building maintenance and repair, and janitorial services.

(8) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

(9) If a clinic fails to submit the OSOW budget by November 1 of the required year, a clinic may not be eligible for compensation of OSOW costs as of January 1 for the coming year.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0420 Re-basing

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

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

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
1-1-07

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
1-1-07

410-147-0460 Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (DMAP) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP).

(2) The PHP Supplemental Payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed DMAP directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-147-0120(13).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and OAR 410-120-1340 Payment.

(5) Supplemental payment by DMAP for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(6) DMAP will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in Section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed DMAP directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by DMAP to report all PHP encounter and payment activity.

(8) To facilitate DMAP processing PHP supplemental payments, the FQHC or RHC must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

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

(b) To DMAP:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for

capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual DMAP performing provider numbers assigned to practitioners associated with the FQHC or RHC. “Associated” refers to a practitioner who is either subcontracted or employed by the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain their individual performing provider number under one of the two situations:

(i) The practitioner maintains a private practice; or

(ii) The practitioner is also employed by a non-FQHC or RHC site.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to DMAP no later than October 31 of each year.

(9) PHP Supplemental Payment process:

(a) DMAP will process PHP Supplemental Payments on a quarterly basis:

(A) Quarterly processing of PHP Supplemental Payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by DMAP to participate in a pilot project, PHP Supplemental Payments will be processed at the discretion of DMAP in collaboration with health centers;

(b) Upon processing a clinic’s data and the PHP Supplemental Payment, DMAP will:

(A) Send a check to the clinic for PHP Supplemental Payment calculated from clinic data DMAP was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by DMAP;

(c) The FQHC or RHC is responsible for reviewing the data DMAP was unable to process for accuracy and completeness. The clinic has 30 days, from the date of DMAP's cover letter under Section (9)(b) of this rule, to make any corrections to the data and resubmit to DMAP for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by DMAP prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing DMAP the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of DMAP's receipt of the re-submitted data, DMAP will:

(A) Review the data and issue a check for all encounters DMAP verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The FQHC or RHC should submit data to DMAP within the timelines provided by DMAP.

(10) Clinics must carefully review in a timely fashion the data that DMAP was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to

DMAP's attention within the time frames outlined, DMAP will not process an adjustment.

(11) DMAP encourages FQHCs and RHCs to request PHP Supplemental Payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to DMAP. (See also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, DMAP is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, DMAP is not required to make a supplemental payment to the clinic. DMAP is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a PHP.

(15) DMAP will not reimburse some Medicaid covered services that are only reimbursed by PHPs, and are not reimbursed by DMAP. DMAP will not make PHP supplemental payment for these services, as DMAP does not reimburse these services when billed directly to DMAP.

(16) It is the responsibility of the FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The Provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an “open card” or “fee-for-service” basis.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

1-1-07

410-147-0480 Cost Statement (DMAP 3027) Instructions

(1) The Division of Medical Assistance Programs (DMAP) requires Federally Qualified Health Centers (FQHC) to submit Cost Statements (DMAP 3027).

(2) Rural Health Clinics (RHC) can choose to submit either their Medicare Cost Report or the Cost Statement (DMAP 3027). If the RHC files a Medicare Cost Report, DMAP may request additional information.

(3) DMAP reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Contraceptive supplies and contraceptive medications. Refer to OAR 410-147-0280;

(b) Pharmacy. Requires separate enrollment, refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(c) Durable Medical Equipment and Supplies. Requires separate enrollment, refer to OAR 410 Division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and

(d) Targeted Case Management (TCM) services. Requires separate enrollment, refer to OAR 410-147-0610, and OAR 410 Division 138, Targeted Case Management for specific information.

(4) Payment for services provided by FQHCs and RHCs is in accordance with 42 USC 1396a(bb). In general, a Prospective Payment System (PPS) encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by an FQHC or RHC for furnishing services by the total number of clinic encounters as defined

in OAR 410-147-0500. A clinic must submit Cost Statement (DMAP 3027) to DMAP:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services. Refer to OAR 410-147-0360;

(b) For new clinics. Refer also to OAR 410-147-0360; or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated. See also OAR 410-147-0320(8).

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

(6) Each section must be completed if applicable.

(7) Page 1 -- Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, the DMAP provider number, the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the DMAP 3027 Cost Statement.

(b) The Cost Statement (DMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

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

(a) FTE Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff. Refer also to OAR 410-147-0500, Total Encounters for Cost Reports. Exclude the following types of encounters from your total encounters:

(A) Outstationed Outreach Workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320.

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

(a) Record the expenses for covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether DMAP allows the costs is subject to the regulations prescribing the treatment of specific items under the Medicaid program. Refer also to OAR 410-147-0020 Professional Services. Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs;

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community Services/Housing Projects. Refer to OAR 410-120-1200;

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public Education; and

(vi) Outside services;

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs;

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;

(vii) Bad debts;

(viii) Other interest expense;

(ix) Advertising;

(x) Membership dues for public relations purposes, including country or fraternal club memberships;

(xi) Cost of personal use of motor vehicles;

(xii) Cost of travel incurred in connection with non-patient care related purposes; and

(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (Related Party Transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity. Refer to OAR 410-147-0540;

(b) 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. A schedule of any reported

reclassification of trial balance expense, whether an increase or decrease, must include:

(A) A reference to the line number on either page 3 or 4;

(B) A description of the reclassification or adjustment;

(C) The amount of the debit or credit; and

(D) The total for each debit and credit;

(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;

(e) Enter the totals from each column in the “Total” fields.

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

(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (DMAP 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 Outreach Workers on line C1, divide the wages by the number of billable DMAP encounters to determine the rate per encounter. See also OAR 410-147-0400.

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

Stats. Implemented: ORS 414.065

1-1-07

410-147-0500 Total Encounters for Cost Reports

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and;

(c) Encounters regardless of line placement on the Health Services Commission's Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the HSC Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP).

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).

(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients;

(e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters:

(a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment. e.g. Targeted Case Management;

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid

beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale “free to the public” or “nominal fee” effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic’s cost statement for calculating a clinic’s PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

(A) Case management services for coordinating health care for a client;

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness;

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by DMAP in OAR 410-147-

0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), OAR 410-130-0595, programs. See also OAR 410-120-1200(2)(y);

(d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) "99211" encounters; and

(D) Maternity Case Management (MCM) encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-

0040(5) ICD-9-CMm Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and “included” in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-07

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 the Division of Medical Assistance Programs (DMAP). 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
1-1-07

410-147-0540 Related Party Transactions

(1) A “related party” is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:

(a) “Common ownership” exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;

(b) “Control” exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(2) Division of Medical Assistance Programs (DMAP) allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, 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.

(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.

(4) Clinics must disclose a related party who is enrolled as a provider with DMAP with a separate DMAP provider number.

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

(6) DMAP will allow rental expense paid to related individuals or organizations for facilities or equipment 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 FQHC and RHC Administrative Rules.

(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

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

Stats. Implemented: ORS 414.065

1-1-07

410-147-0560 Sanctions

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

(a) Failure to comply with DMAP 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 DMAP. The FQHC or RHC will not be permitted to re-enroll without first demonstrating to theDMAP satisfaction:

(A) That it is complying with and will continue to comply with all DMAP 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 DMAP 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 DMAP FQHC and RHC Program Manager for details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-07

410-147-0610 Targeted Case Management (TCM)

(1) Targeted Case Management (TCM) services are provided and reimbursed through a separate program requiring enrollment as a TCM provider.

(2) Refer to OAR 410 Division 138, Targeted Case Management, for specific requirements.

(3) If an FQHC or RHC is participating in a TCM program, the clinic must notify the Division of Medical Assistance Programs (DMAP) in writing and must include a description of the TCM program. With the exception of maternity case management (MCM) services authorized by OAR 410-147-0200, costs for TCM services cannot be included in a clinic's cost statement and cannot be billed as an encounter under the FQHC or RHC per a clinic's encounter rate, or billed to a prepaid health plan (PHP).

(4) A client may only participate in a single TCM program. DMAP does not allow multiple TCM billings. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07

410-147-0620 Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medicaid coverage under the Oregon Health Plan (OHP), coordinated by the Division of Medical Assistance Program (DMAP), providers must bill Medicare first.

(2) All claims submitted by Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) to DMAP for clients who have both Medicare and DMAP coverage must be billed on a CMS-1500 claim form or by 837P transmission. See also Billing for Medicare/Medicaid Clients in the FQHC and RHC Supplemental Information.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form or 837P transmission, but only after that carrier has made payment determination.

(4) When billing on a CMS-1500 claim form or 837P transmission for a client with both Medicare and DMAP coverage:

(a) Bill all services provided to an OHP beneficiary using a procedure code listed in Table 147-0120-1, FQHC/RHC Encounter Codes;

(b) Bill the clinic's encounter rate; and

(c) Enter the total Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation. Refer to CMS-1500 or 837P detailed billing instructions.

(5) Claims for Qualified Medicare Beneficiary (QMB)-only clients must be billed on CMS-1500 claim form or 837P transmission. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information and instructions are located in the FQHC and RHC Supplemental Information billing guide:

(a) The total charged amount must equal the total Medicare allowed/covered charges, minus any reductions or contract adjustments. FQHCs and RHCs are not to bill their encounter rate for

services provided to Qualified Medicare Beneficiary (QMB)-only clients;

(b) FQHC and RHCs must bill each service, treatment or item provided to a QMB-only beneficiary on the CMS-1500 claim form or 837P transmission identical to how Medicare was billed.

(c) For claims to process payment correctly, FQHCs and RHCs billing multiple services need to apply the total charge calculated, according to section (a) above, to the first detail line and zero charge all subsequent lines. Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-07