



Oregon

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To: OMAP Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Service Providers

From: Joan Kapowich, Manager
OMAP Program and Policy

Re: FQHC Rules, RB Revision 2

Effective: August 1, 2004

OMAP updated the FQHC/RHC Program Rulebook as follows:

OMAP adopted 410-147-0125 and amended rules 410-147-0085 and 410-147-0120 to implement modifications to the Oregon Health Plan (OHP) Standard Benefit Package as directed by the 2003 Legislative Assembly in HB 2511. Some benefits are restored while other benefits are removed. Implementation of these amendments is approved by the Centers for Medicare and Medicaid Services (CMS).

The Table of Contents is updated.

- If you are reading this letter on OMAP's website: (<http://www.dhs.state.or.us/policy/healthplan/rules/>), this Administrative rulebook contains a complete set of rules for this program, including the above revisions.
- If you receive hardcopy of revisions, this letter is attached to the revised rules and Table of Contents, to be used as replacements in your rulebook. Each rule is numbered individually for easy replacement.

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

TR 557 8/1/04

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DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 147

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Rural Health Clinic (RHC)**

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410-147-0000 Foreword

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-02

410-147-0020 Professional Services

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

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

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

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

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

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

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

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

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

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0060 Prior Authorization

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0080 Managed Care Organizations (MCOs)

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

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

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

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

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(5) MCOs are responsible for interpretation services.

(6) Maternity Case Management (MCM) services:

(a) Providing MCM services is optional for MCOs;

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

(A) Determine if the MCO provides MCM services;

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0085 Client Copayments

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

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

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

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

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

(2) OHP Standard benefit package:

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

410-147-0120 Encounter

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

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

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

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

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

(a) Medical;

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

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

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

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

(e) Nurse Practitioners;

(f) Nurse Midwives;

(g) Other specialized nurse practitioners;

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

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

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

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

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

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

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

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

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

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

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

(f) Death with Dignity services;

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

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

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

(11) Codes for Encounters:

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

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

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

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

Table 147-0120-1

Table 147-0120-2

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

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

Effective August 1, 2004

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

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

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

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

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

Table 147-0120-2 OHP Plus Dental Services

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

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

D5922	D5986	D7471	D7911	D8690
D5923	D5987	D7490	D7912	D8999
D5924	D6930	D7510	D7920	D9110
D5925	D6972	D7520	D7950	D9211
D5926	D6980	D7530	D7970	D9212
D5928	D7111	D7540	D7980	D9220
D5929	D7140	D7550	D7981	D9221
D5931	D7210	D7560	D7982	D9230
D5932	D7220	D7610	D7983	D9241
D5933	D7230	D7620	D7990	D9242
D5934	D7240	D7630	D7997	D9248
D5935	D7241	D7640	D8010	D9310
D5936	D7250	D7650	D8020	D9420
D5937	D7260	D7660	D8030	D9430
D5951	D7270	D7670	D8040	D9440
D5952	D7285	D7680	D8050	D9610
D5953	D7286	D7710	D8060	D9630
D5954	D7287	D7720	D8070	D9930
D5955	D7320	D7730	D8080	D9999
D5958	D7340	D7740	D8090	
D5959	D7350	D7750	D8210	8-1-04
D5960	D7440	D7760	D8220	
D5983	D7441	D7770	D8660	
D5984	D7450	D7780	D8670	
D5985	D7451	D7910	D8680	

410-147-0125 OHP Standard Emergency Dental Benefit

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

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

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

Table 147-0125-1 OHP Standard Dental Services

Effective August 1, 2004

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

D0140	D0270	D3220	D7230	D7520	D9420
D0170	D0272	D3221	D7240	D7911	D9440
D0220	D0330	D6930	D7241	D9110	
D0230	D2910	D7111	D7250	D9210	8-1-04
D0240	D2920	D7140	D7260	D9215	
D0250	D2940	D7210	D7270	D9230	
D0260	D3110	D7220	D7510	D9410	

410-147-0140 Multiple Encounters

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

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

(a) Medical:

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

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

(b) Dental;

(c) Mental Health;

(d) Alcohol and Drug;

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

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

(g) Physical or Occupational Therapy;

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

(i) Tobacco cessation.

(3) OMAP considers more than one outpatient visit with a medical professional within the same date of service for the same condition a single medical encounter. For example, a client comes to the clinic in the morning for an examination, during the examination the client is diagnosed with hypertension. The practitioner prescribes medication and asks the client to return in the afternoon for a blood pressure check.

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

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Stats. Implemented: ORS 414.065

10-1-02

410-147-0160 Modifiers

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

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

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10-1-03

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

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

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

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10-1-02

410-147-0200 Maternity Case Management Services

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

- (2) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant and no later than the day prior to delivery. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the MCM initial evaluation has not been completed prior to the day of delivery.

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

- (4) The MCM program:
 - (a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

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

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

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

- (5) MCM case managers are required to notify the:

(a) Prenatal care provider when:

(A) MCM services have been initiated; and

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

(b) Health Division for all first born babies.

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

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

(8) Definitions:

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

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

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

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

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

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

(A) Initial assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client.

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

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

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

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

(D) Pregnancy weight gain outside WIC guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

(H) Pregnancy induced hypertension (preeclampsia);

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

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

(i) Telephone Contact -- A non-face-to-face client encounter between a maternity case manager and the client, initiated by the maternity case manager, providing education or training related to the CSP and are limited to Case Management Visits only. Telephone contacts must include all the components of the service when provided face-to-face. Telephone contacts are not at the exclusion of face-to-face. Services excluded from telephone contacts are the Initial Assessment, Home Assessment and Nutritional Counseling.

(9) Maternity Case Manager Qualifications:

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

(A) Physician;

(B) Physician Assistant;

(C) Nurse Practitioner;

(D) Certified Nurse Midwife;

(E) Direct Entry Midwife;

(F) Social Worker; or

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

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

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

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

(a) Be a registered dietician; or

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

(11) Documentation Requirements:

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

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

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

(a) Includes:

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

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

(C) Making referrals as needed;

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

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

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

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

(c) Paid one time per pregnancy per provider.

(13) Case Management – Includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

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

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

(c) Referral to services included in the CSP:

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

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

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

(e) For training, information, and education requirements: Refer to Table 147-0200-1;

(f) Linkage to labor and delivery services;

(g) Linkage to family planning services as needed;

(h) CSP coordination as follows:

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

(B) Contact with prenatal care provider;

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

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

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

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

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

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) On-going regular client follow-up.

(c) Paid one time per pregnancy.

(15) Home/Environment Assessment:

(a) Includes an assessment of the health and safety of the client's living conditions with training and education as indicated in Table 147-0200-1;

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

(16) Telephone Contact:

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

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

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

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

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

(17) Case Management Visit:

(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and training, information and education regarding at least two in Table 147-0200-1;

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

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

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10-1-03

Table 147-0200-1 MCM Education, Training and Prevention Topics

Client Service Plan

Training & Education Maternal/Fetal HIV Transmission Fetal Alcohol Syndrome Prevention Early Childhood Caries Maternal Oral Health Prevention for Tobacco Use Lead Exposure and Screening Immunizations
--

Environmental Assessment

<p>General Assessment</p> <ul style="list-style-type: none">◆ General Condition of House◆ Adequacy of Shelter◆ Food Storage Facilities and Food Preparation Facilities◆ Health Adequacy: Safety and sanitation.◆ Heating/Cooling/Ventilation◆ Number of Bedrooms vs. Number of People◆ Running water◆ Phone service◆ Sanitation/Sewer◆ Environmental Hazards◆ Toxins/Teratogens
--

<p>Safety</p> <ul style="list-style-type: none">◆ Guns: Locked and Unloaded◆ Smoke Alarm: Installed & Working◆ Fire Prevention: For example smoking habits, if applicable.◆ Adequate Exits: All locations and free of obstacles. <p>Toxins</p> <ul style="list-style-type: none">◆ Lead Exposure: Peeling paint, lead pipes, or lead dust.◆ Chemical Use: In or near home.◆ Asbestos. <p>Pet</p> <ul style="list-style-type: none">◆ Cats (Toxoplasmosis)◆ Birds (Psittacosis)◆ Reptiles (Salmonella), i.e., iguanas, turtles, snakes

Table 147-0200-1 MCM Education, Training and Prevention Topics

Case Management Visits

<p>Pre-term birth prevention Factors associated with increased risk Early detection of symptoms Obtaining help/information Stress reduction Oral Health Status</p>	<p>Emotional Stress reduction Coping strategies Hormonal changes Relationships</p>
<p>Pregnancy & Childbirth Common discomforts Pregnancy danger signs & symptoms Labor and birth process Coping strategies Common interventions Emergencies</p>	<p>Other Family planning Sexually Transmitted Diseases Substance/alcohol use Infant Care/Parenting Feeding/nutrition/infant growth Clothing needs Infant sleep patterns and location Wellness care/immunizations Prevention of Early Childhood Cavities Breastfeeding SIDS and Back To Sleep Developmental milestones Common interventions Emergencies</p>
<p>Health Status Rest/exercise Digestive tract changes Weight gain Food availability Food selection/preparation Nutrition Nutrient/calorie intake Medications</p>	<p>Safety Infant/parent interaction Bonding/attachment Infant communication patterns/cues Parental frustration/sleep deprivation Household management support Community resources Child nurturing/protection</p>
<p>Environment Health Adequacy, Safety and Sanitation Environmental Hazards Toxins/Teratogens Fluoridated Water Area</p>	

410-147-0220 Tobacco Cessation

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

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

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10-1-02

410-147-0240 Administrative Medical Examinations and Reports

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

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

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10-1-02

410-147-0260 Death With Dignity

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

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

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

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10-1-02

410-147-0280 Drugs

Follow criteria outlined in the following:

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

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10-1-03

410-147-0320 FQHC/RHC Enrollment

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

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

(b) Cost Statement Worksheet (OMAP 3032);

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

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

(e) Depreciation schedules;

(f) Overhead cost allocation schedules; and

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

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

(2) FQHC Enrollment:

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

(A) Centers receiving Public Health Services (PHS) grant funds under authority of Section 330 – Migrant Health Centers, Community Health Centers, or Services to Homeless Individuals, must submit: a copy of the notice of current grant award, an Office of Medical Assistance Programs (OMAP) Provider Application (OMAP 3117), documents

showing the clinic's scope of services, and the required financial documents;

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

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

(D) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians, the clinic must submit: a copy of the award/contract from the Indian Health Services with an OMAP Provider Application (OMAP 3117), documents showing the clinic's scope of services, and the required financial documents.

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

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

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

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

(f) A list of all MCO contracts;

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

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

(3) RHC Enrollment:

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

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

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

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

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

(c) Submit one of the following to OMAP:

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

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

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

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

(f) A list of all MCO contracts;

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

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

(4) Tribal Facility Enrollment:

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

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

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

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

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

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

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10-1-03

410-147-0340 FQHC and RHC Clinic 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) OMAP may grant exception to section (1) of this rule upon written request. The request needs to include documentation describing in detail the need for multiple provider numbers and outlining the mechanisms in place to assure no duplication of billings. If multiple clinic numbers are provided and OMAP finds evidence of duplicate billings or failure to use the billing provider number as required, the exception for multiple provider numbers will be terminated upon written notice to the clinic. Contact the OMAP's FQHC/RHC Program Manager for details.

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

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

(5) If OMAP grants an exception to section (1) of this rule the FQHC or RHC will be issued a billing provider number for the main administrative site and a separate performing provider number for each clinic site. If the main administrative site also has a clinic at that 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 are required to enter the billing provider number in Field 33, and the clinic site provider number in Field 24K of the CMS-1500 when submitting claims to OMAP. The main

administrative office with a clinic site must list the billing provider number in Field 33 and their clinic provider number in Field 24K.

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

(a) A billing provider number, and;

(b) Performing provider numbers for each practitioner.

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

(8) Clinic provider number(s) will not be issued until after the encounter rate is established.

(9) Previous clinic/provider numbers for the clinic will be closed the day the FQHC/RHC clinic number is issued.

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10-1-03

410-147-0360 Initial Encounter Rate Determination

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

(a) Payment under PPS is effective the date a clinic's encounter rate is determined and cannot be used to bill for services provided prior (retroactive) to the established encounter rate;

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

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

(3) To determine an encounter rate as an:

(a) FQHC, submit the following:

(A) Cost Statement (OMAP 3027);

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

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

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

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

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

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

(H) A list of all MCO contracts;

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

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

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

(A) A copy of:

(i) Uncertified Medicare Cost Report;

(ii) Certification as an RHC;

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

(iv) Documentation that shows the clinic's geographic scope of services.

(B) A copy of:

(i) Cost Statement (OMAP 3027);

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

(iii) Certification or other documents showing RHC status;

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

(v) Documentation showing the geographic scope of services;

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

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

(viii) A list of all MCO contracts;

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

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

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

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

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

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

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

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

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

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

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

(b) Sanctions may be imposed as defined in OAR 410-147-0560.

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-03

410-147-0380 Accounting and Record Keeping

(1) General Requirements:

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

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

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

(d) Must adhere to acceptable accounting standards.

(2) Rules and Regulations:

(a) FQHC and RHC Administrative Rules;

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

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

(d) All other applicable OMAP provider rules.

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

(4) Each FQHC and RHC shall:

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

(b) Maintain complete client documentation;

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

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

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

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

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

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

(B) Do not serve Medical Assistance Program clients.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0400 Compensation for Outstationed Eligibility Workers

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0420 Re-basing

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

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

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-03

410-147-0440 Medicare Economic Index (MEI)

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

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-02

410-147-0460 Managed Care Organization Supplemental Payments

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

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

(a) To MCOs:

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

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

(b) To OMAP:

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

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

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

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

(3) MCO Supplemental Payment process:

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

10-1-03

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

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

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

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

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

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

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

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

(5) Each section must be completed if applicable.

(6) Page 1 -- Statistical Information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stats. Implemented: ORS 414.065

10-1-03

410-147-0500 Total Encounters for Cost Reports

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

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

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

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

(A) Client's name;

(B) Date of service; and

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0520 Depreciation

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

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

Stats. Implemented: ORS 414.065
10-1-02

410-147-0540 Related Party Transactions

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

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

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

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

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

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

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

Stats. Implemented: ORS 414.065

10-1-02

410-147-0560 Sanctions

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

410-147-0610 Targeted Case Management (TCM)

- (1) TCM is excluded from the FQHC/RHC encounter rate.
- (2) If the FQHC or RHC is participating in a TCM program, HCPCS code T2023 must be used with the appropriate modifier. Refer to Table 147-0120-1 for specific details regarding modifiers used for TCM:
- (3) If the appropriate modifier is not used with T2023 the claim will be denied.
- (4) If the FQHC or RHC is participating in a TCM program, the clinic must notify OMAP in writing and must include the description of the TCM program.
- (5) A client may only participate in a single TCM program. Multiple TCM billings will not be allowed. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-03

410-147-0620 Medicare/Medical Assistance Program Claims

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

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

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

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02