

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number
Cheryl Peters, 500 Summer St Ne, Salem, OR 97301	503-945-6527
Rules Coordinator	Address
	Telephone

RULE CAPTION

Revisions to definitions, Program Integrity, Provider enrollment and technical corrections.

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

June 15, 2012	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
Hearing Date	Time	Location	Hearings Officer

*Auxiliary aids for persons with disabilities are available upon advance request.***RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

AMEND: 410-120-0000, 410-120-0025, 410-120-0250, 410-120-1260, 410-120-1340, 410-120-1395.

Stat. Auth. : ORS 413.042 and ORS 183.341

Other Auth.:

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.651, 414.705, 414.727, 414.728, 414.737, 414.742, 414.743

RULE SUMMARY

The General Rules program administrative rules govern Division payments for services to clients. The Division will amend as follows: OAR 410-120-0000, Add a definition for "indigent" and having temporarily amended 410-120-0000 effective March 16, 2012, the Division will permanently amend this rule to reflect definitions added or moved from other program rules. OAR 410-120-1260, Federal law requires State Medicaid agencies to perform specific provider screening, enrollment and reenrollment processes. The rule will be revised to reflect compliance with Section 6401 of the Affordable Care Act. Revisions will also be made to OAR 410-120-1340 due to the changes made to OAR 410-120-1260 as noted above. Some other minor "readability" revisions are also made. OAR 410-120-1395, revisions include notifications to providers who are excluded from Medicaid and notifications to the Office of Inspector General regarding provider disclosures. Technical corrections to statute numbers will be made to OAR 410-120-0025 and 410-120-0250. Having temporarily amended 410-120-1860 effective February 1, 2012, the Division will permanently amend this rule to reflect that contested case procedures timelines of a hearing request is based on the date the Authority receives it, not the date of the postmark. The Division will also repeal OAR 410-120-0027, this rule was a temporary measure and is no longer needed.

June 18, 2012

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Signature	Printed name	Date
*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005		

Statement of Need and Fiscal Impact

A Notice of Rulemaking or Rulemaking Hearing accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) _____ 410
Agency and Division Administrative Rule Chapter Number

In the Matter of: The proposed amendment of administrative rules that govern payment for the General Rules Program. The Division will amend 410-120-0000, 410-120-0025, 410-120-0250, 410-120-1260, 410-120-1340, 410-120-1395. The Division will also permanently amend the temporary rule 410-120-1860 (T), 410-120-0000(T) and repeal 410-120-0027.

Rule Filing Caption: Revisions to definitions, Program Integrity, Provider enrollment and technical corrections.

Statutory Authority: 183.341, 413.042

Other Authority: None

Statutes Implemented: 414.025, 414.033, 414.065, 414.095, 414.651, 414.705, 414.727, 414.728, 414.737, 414.742, 414.743

Need for Rule(s): The General Rules program administrative rules govern Division payments for services to clients. The Division will amend as follows:

- **OAR 410-120-0000, Definitions:** Adding a new definition of indigent as a result of HB. 2103 passed into law 6/14/11. Also, having temporarily amended 410-120-0000 effective March 16, 2012, the Division will permanently amend this rule to reflect definitions added or moved from other program rules.
- **OAR 410-120-0025, Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence:** Technical correction statute renumbered.
- **OAR 410-120-0250, Managed care organization:** statute renumbered, include CCO as a MCO type.
- **OAR 410-120-1260, Provider Enrollment:** Section 6401 of the Affordable Care Act requires State Medicaid agencies to perform specific provider screening, enrollment and reenrollment processes. The rule will be revised to reflect compliance with this Federal law.
- **OAR 410-120-1340, Payment:** Revisions made are due to the changes made to 410-120-1260 provider screening rule noted above. Some minor 'readability' revisions are also made.
- **OAR 410-120-1395, Program Integrity:** CMS 2010 Program Integrity Audit recommended 2 items to include in the OAR (1) regarding the notification to providers who are excluded from Medicaid and (2) Provider disclosure notifications to the Office of Inspector General.
- **OAR 410-120-1860, Contested Case Hearing procedures:** Having temporarily amended 410-120-1860 effective February 1, 2012, the Division will permanently amend this rule to reflect that contested case procedures timeliness of a hearing request is based on the date the Authority receives it, not the date of the postmark.

The Division will repeal:

- **OAR 410-120-0027, MMIS Alternative Process and Procedure:** This rule was a temporary measure put into place for the transition between the Divisions old MMIS and new MMIS system. The rule is no longer needed

Documents Relied Upon, and where these can be viewed or obtained:

410-120-0000- H.B. 2103, http://www.leg.state.or.us/bills_laws/

410-120-1260- The Patient Protection and Affordable Care Act ((H.R. 3590) Section 6402, <http://democrats.senate.gov/pdfs/reform/patient-protection-affordable-care-act-as-passed.pdf>

410-120-1860- Statewide rules in Division 137-003 are scheduled to be filed on January 31, 2012 available at http://www.doj.state.or.us/help/pdf/amended_proposed_rules_71411.pdf

Fiscal and Economic Impact, including Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

410-120-0000, 410-120-0025, and 410-120-0250- no impact to other agencies or the public

410-120-1260- There is an increased workload to the agency and an increase in expenditures due to the cost of the application fee to providers. It is not possible to estimate the increase as the application fee is a one time fee and the provider may have already paid it to another state Medicaid program or to Medicare.

410-120-1860- Does not impact other agencies but could impact the public if they are requesting a hearing near to the deadline date.

410-120-1340, 410-120-1395- No impact to the public, impacts the agency responsible for Medicaid provider enrollment for increased administrative work.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The Division has approximately 63,000 enrolled providers. These enrolled providers range from large hospital affiliates, national Durable Medical Equipment or Pharmacy chains to individually owned physician offices. The Division's fee-for-services providers serve approximately 15% of the total OHP population. The Division does not have available information to estimate the percentage of these medical practices that are small businesses, but it is likely that there is a significant number of them.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

OAR 410-120-0000, 410-120-0025, 410-120-0250, 410-120-1340, 410-120-1395 and 410-120-1860: These rule revisions are not likely to add additional reporting, record keeping or other administrative activities.

OAR 410-120-1260: This rule is likely to have some minor additional reporting, record keeping or other administrative activities related to compliance with the Federal law.

c. Equipment, supplies, labor and increased administration required for compliance:

OAR 410-120-0000, 410-120-0025, 410-120-0250, 410-120-1340, 410-120-1395 and 410-120-1860: These rule revisions impose no new equipment, supplies, labor and increased administration requirements on small businesses.

OAR 410-120-1260: compliance with the Federal law may require some increased administration requirements on small businesses, but does not impose any new equipment, supply or labor activities.

How were small businesses involved in the development of this rule?: Approximately two weeks prior to the rules advisory committee meeting a public notice was posted on the agency website, an invitation was emailed to more than 250 people that had expressed interest in the rule making process as well as those that participated in the earlier rate reduction meetings referenced above. Those invited are made up of large and small providers groups and associations, however none of the individuals attending the February 17, 2012 meeting indicated they were representing a small business.

Administrative Rule Advisory Committee consulted? If not, why?: Yes, a RAC was held on February 17, 2012, details are as outlined in the question above.

Other Agencies affected: None.

Proposed Effective date: On or after July 1, 2012

Authorized Signers: _____
Judy Mohr Peterson, Jean Donovan or Sandy Wood Date

410-120-0000 Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) or the Addictions and Mental health Division (AMH) administrative rules applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions, OAR 410-141-0300, and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 407 administrative rules, or contact the Division.

- (1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority.
- (2) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.
- (3) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.
- (4) "Acute" means a condition, diagnosis or illness with a sudden onset and that is of short duration.
- (5) "Acquisition Cost" means unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.
- (6) "Addiction and Mental Health Division (AMH)" means a division within the Authority that administers mental health and addiction programs and services.
- (7) "Adequate Record Keeping" means documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.
- (8) "Administrative Medical Examinations and Reports" mean examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.
- (9) "Advance Directive" means an individual's instructions to an appointed individual specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.
- (10) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.
- (11) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (DHS) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)".
- (12) "All-Inclusive Rate: means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(13) “Allied Agency” means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(14) “Alternative Care Settings” mean sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities and outpatient surgical centers.

(15) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(16) “Ambulatory Payment Classification” means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(17) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.

(18) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(19) “American Indian/Alaska Native (AI/AN) Clinic” means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(20) “Ancillary Services” mean services supportive of or necessary for providing a primary service, such as, anesthesiology, which is an ancillary service necessary for a surgical procedure.

(21) “Anesthesia Services” mean administration of anesthetic agents to cause loss of sensation to the body or body part.

(22) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(23) “Atypical Provider” means entity able to enroll as a billing provider (BP) or rendering performing provider for medical assistance programs related non-health care services but which does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(24) “Audiologist” means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(25) “Audiology” means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

- (265) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone or Web-based response.
- (276) “Benefit Package” means the package of covered health care services for which the client is eligible.
- (287) “Billing Agent or Billing Service” means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.
- (298) “Billing Provider (BP)” means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from the Division on behalf of a performing rendering provider and has been delegated the authority to obligate or act on behalf of the performing rendering provider.
- (3029) “Buying Up” means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up).
- (310) “By Report (BR): means services designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.
- (324) “Case Management Services” mean services provided to ensure that CCO members obtain health services necessary to maintain physical, mental and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, chemical dependency and/or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency or dental services, referring members to community services and supports which may include referrals to Allied Agencies.
- (332) “Children, Adults and Families Division (CAF)” means a division within the Department, responsible for administering self-sufficiency and child-protective programs.
- (343) “Children's Health Insurance Program (CHIP)” means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.
- (354) “Chiropractor” means a person licensed to practice chiropractic by the relevant state licensing board.
- (365) “Chiropractic Services” mean services provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.
- (376) “Citizen/Alien-Waived Emergency Medical (CAWEM)” means aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (3)(f).
- (387) “Claimant” means a person who has requested a hearing.
- (398) “Client” means an individual found eligible to receive OHP health services. “Client” is inclusive of members enrolled in PHPs, PCMs and CCOs.

(40) “Clinical Nurse Specialist” means a registered nurse who has been approved and certified by the Board to provide health care in an expanded specialty role.

(41~~39~~) “Clinical Social Worker” means a person licensed to practice clinical social work pursuant to State law.

(42~~0~~) “Clinical Record” means the medical, dental or mental health records of a client or member.

(43~~4~~) “Comfort Care” means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

(44~~2~~) “Contested Case Hearing” means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an action:

(a) A client or member or their representative;

(b) A PHP or CCO member’s provider; or

(c) A PHP or CCO.

(45~~3~~) “Contiguous Area” means the area up to 75 miles outside the border of the State of Oregon.

(46~~4~~) “Contiguous Area Provider” means a provider practicing in a contiguous area.

(47~~5~~) “Continuing Treatment Benefit” means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client’s benefit package changed to one that does not cover the treatment.

(48~~6~~) “Co-Payments” mean the portion of a claim or medical, dental or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment).

(49~~7~~) “Cost Effective” means the lowest cost health care service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

(50~~48~~) “Current Dental Terminology (CDT)” means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(51~~49~~) “Current Procedural Terminology (CPT)” means the physicians’ CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(52~~0~~) “Date of Receipt of a Claim” means the date on which the Authority receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(53~~4~~) “Date of Service” means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(54~~2~~) “Dental Emergency Services” mean dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(553) “Dental Services” mean services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(564) “Dentist” means a person licensed to practice dentistry pursuant to state law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(575) “Denturist” means a person licensed to practice denture technology pursuant to State law.

(56) “Denturist Services” mean services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

(587) “Dental Hygienist” means a person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(598) “Dental Hygienist with an Expanded Practice Permit” means a person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to State law.

(6059) “Dentally Appropriate” means services that are required for prevention, diagnosis or treatment of a dental condition and that are:

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

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

(c) Not solely for the convenience of the client or a provider of the service;

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

(610) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

(624) “Department Representative” means a person who represents the Department and presents the position of the Department in a hearing.

(632) “Diagnosis Code” means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(643) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(654) “Division of Medical Assistance Programs (Division)” means a division within the Authority; the Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

(665) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” mean equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces.

Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(~~6667~~) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medichex)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(~~687~~) “Electronic Data Interchange (EDI)” means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(~~698~~) “EDI Submitter” means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(~~7069~~) “Electronic Verification System (EVS)” means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

(~~710~~) “Emergency Department” means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(~~724~~) “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

(~~732~~) “Emergency Medical Transportation” means transportation necessary for a client with an emergency medical condition, as defined in this rule, and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(~~743~~) “Emergency Services” means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.

(~~754~~) “Evidence-Based Medicine” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased

expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

(765) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an overpayment.

(776) "Family Health Insurance Assistance Program (FHIAP)" means a program in which the State subsidizes premiums in the commercial insurance market for uninsured individuals and families with income below 185% of the Federal Poverty Level.

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

(7879) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(8079) "Fee-for-Service Provider" means a health care ~~medical~~ provider who is not reimbursed under the terms of a Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP); ~~also referred to as a Managed Care Organization (MCO)~~. A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

(810) "Flexible Service" means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, chemical dependency condition, or physical condition as documented in the Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Services, and other non-Traditional Services identified.

(824) "Flexible Service Approach" means the delivery of any Coordinated Care Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Coordinated Care Services at alternative sites such as schools, residential facilities, nursing facilities, Members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours; offering Coordinated Care Services through outreach or a home-based approach; and using peers, paraprofessionals, Community Health Workers, Peer Wellness Specialists, or Personal Health Navigators who are Culturally Competent to engage difficult-to-reach Members.

(832) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(843) “Fully Dual Eligible” means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(854) “General Assistance (GA)” means medical assistance administered and funded 100% with State of Oregon funds through OHP.

(865) “Healthcare Common Procedure Coding System (HCPCS)” means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(876) “Health Care Professionals” mean individuals with current and appropriate licensure, certification or accreditation in a medical, mental health or dental profession who provide health services, assessments and screenings for clients within their scope of practice, licensure or certification.

(887) “Health Evidence Review Commission” means a commission that, among other duties, develops and maintains a list of health services ranked by priority, from the most to the least important, representing the comparative benefits of each service to the population served.

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

(9089) “Health Maintenance Organization (HMO)” means a public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(910) “Health Plan New/noncategorical client (HPN)” means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet all eligibility requirements to become an OHP client.

(924) “Hearing Aid Dealer” means a person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(932) “Home Enteral Nutrition” means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(943) “Home Health Agency” means a public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(954) “Home Health Services” mean part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(965) “Home Intravenous Services” mean services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(9697) “Home Parenteral Nutrition” means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(987) “Hospice” means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, and is certified **certified** by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(998) “Hospital” means a facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as long-term care hospitals, long-term acute care hospitals or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state, and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(10099) “Hospital-Based Professional Services” mean professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (Division 42) report for the Division.

(101) “Hospital Dentistry” means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(1020) “Hospital Laboratory” means a laboratory providing professional technical laboratory services as outlined under laboratory services, in a hospital setting, as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(1034) “Indian Health Care Provider” means an Indian health program or an urban Indian organization.

(1042) “Indian Health Program” means any Indian Health Service (IHS) facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(1053) “Indian Health Service (IHS)” means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives.

(106) “Indigent” means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602) indigent has the meaning: Individuals without health insurance coverage, public or private and meet standards for indigence adopted by the federal government as defined in ORS 813.602 (5).

(1074) “Individual Adjustment Request Form (DMAP 1036)” means form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(1085) “Inpatient Hospital Services” mean services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(1096) “Institutional Level of Income Standards (ILIS)” mean three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities’ (SPD) Home and Community Based Waiver.

(1107) “Institutionalized” means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(1118) “International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)” mean a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(1129) “Laboratory” means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory, under the Clinical Laboratory Improvement Act (CLIA).

(1139) “Laboratory Services” mean those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(1144) “Licensed Direct Entry Midwife” means a practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the Public Health Division.

(1152) “Liability Insurance” means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner’s liability insurance, malpractice insurance, product liability insurance, Worker’s Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(1163) “Managed Care Organization (MCO)” means contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(1174) “Maternity Case Management” means a program available to pregnant clients. The purpose of Maternity Case Management is to extend prenatal services to include non-medical services, which address social, economic and nutritional factors. For more information refer to the Division’s Medical-Surgical Services Program administrative rules.

(1185) “Medicaid” means a federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Authority.

(1196) “Medical Assistance Eligibility Confirmation” means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

(12017) “Medical Assistance Program” means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project, and Medicaid and CHIP services under the State Plan.

(12118) “Medical Care Identification” means the card commonly called the "medical card" issued to clients.

(12219) “Medical Services” mean care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

(1230) “Medical Transportation” means transportation to or from covered medical services.

(1241) “Medically Appropriate” means services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

- (a) Consistent with the symptoms of a health condition or treatment of a health condition;
- (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;
- (c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and
- (d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Division client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(1252) “Medicare” means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

- (a) Hospital Insurance (Part A) for Inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and
- (b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;
- (c) Prescription drug coverage (Part D) means covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title

XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(1263) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(1274) "Medicheck for Children and Teens" mean services also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(1285) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(1296) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

(13027) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(13128) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

(13229) "National Provider Identification (NPI)" means federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(1330) "Naturopath" means a person licensed to practice naturopathy pursuant to State law.

(1341) "Naturopathic Services" means services provided within the scope of practice as defined under State law.

(1352) "Non-covered Services" mean services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

- (a) OAR 410-120-1200, Excluded Services and Limitations; and
- (b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;
- (c) 410-141-0480, OHP Benefit Package of Covered Services;
- (d) 410-141-0520, Prioritized List of Health Services; and

(e) Any other applicable Division administrative rules.

(136) “Non-Paid Provider” means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

(137~~3~~) “Nurse Anesthetist, C.R.N.A.” means a registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

(138~~4~~) “Nurse Practitioner” means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

(139~~5~~) “Nurse Practitioner Services” mean services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

(140~~36~~) “Nursing Facility” means a facility licensed and certified by the Department SPD and defined in OAR 411-070-0005.

(141~~37~~) “Nursing Services” mean health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

(142~~38~~) “Nutritional Counseling” means counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(143~~39~~) “Occupational Therapist” means a person licensed by the State Board of Examiners for Occupational Therapy.

(144~~0~~) “Occupational Therapy” means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(145~~4~~) “Ombudsman Services” mean advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of or limitations on the health services provided.

(146~~2~~) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project which expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations, and Medicaid and CHIP services under the State Plan

(147~~3~~) “Optometric Services” mean services provided, within the scope of practice of optometrists as defined under State law.

(148~~4~~) “Optometrist” means a person licensed to practice optometry pursuant to State law.

(149~~5~~) “Oregon Health Authority (Authority or OHA)” means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the OHA are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(15046) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(15147) "Out-of-State Providers" mean any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(15248) "Outpatient Hospital Services" mean services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules found in chapter 410, division 125.

(15349) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(1540) "Overpayment" means payment(s) made by Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(1554) "Overuse" means use of medical goods or services at levels determined by Authority medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(156) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(1572) "Panel" means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(1583) "Payment Authorization" means authorization granted by the responsible agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(1594) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

(16055) "Pharmaceutical Services" mean services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(16156) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(16257) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(16358) "Physical Therapist" means a person licensed by the relevant State licensing authority to practice Physical Therapy.

- (16459) “Physical Therapy” means treatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.
- (1650) “Physician” means a person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government.
- (1664) “Physician Assistant” means a person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.
- (1672) “Physician Services” mean services provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.
- (1683) “Podiatric Services” mean services provided within the scope of practice of podiatrists as defined under state law.
- (1694) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to state law.
- (17065) “Post-Payment Review” means review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.
- (17166) “Practitioner” means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.
- (17267) “Premium Sponsorship” means premium donations made for the benefit of one or more specified Division clients (See 410-120-1390).
- (17368) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)
- (17469) “Primary Care Dentist (PCD)” means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.
- (1750) “Primary Care Physician” means a physician who has responsibility for supervising, coordinating and providing initial and primary care to patients, initiating referrals for consultations and specialist care, and maintaining the continuity of patient care.
- (1764) “Primary Care Provider (PCP)” means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically appropriate client care.
- (1772) “Prior Authorization (PA)” means payment authorization for specified medical services or items given by Authority staff, or its contracted agencies prior to provision of the service. A physician referral is not a PA.

(1783) “Prioritized List of Health Services” mean the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.

(1794) “Private Duty Nursing Services” mean nursing services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's physician to an individual who is not in a health care facility.

(18075) “Provider” means an individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing rendering provider, or bills, obligates and receives reimbursement on behalf of a performing rendering provider of services, also termed a billing provider (BP). The term provider refers to both performing rendering providers and BP(s) unless otherwise specified.

(18176) “Provider Organization” means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility or organization;

(e) If such entity solely submits billings on behalf of providers and payments are made to each provider, then the entity is an agent. (See Subparts of Provider Organization).

(18277) “Public Health Clinic” means a clinic operated by a county government.

(18378) “Public Rates” mean the charge for services and items that providers, including Hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

(18479) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary, as defined by the Social Security Act and its amendments.

(1850) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.

(1864) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.

(1872) “Quality Improvement Organization (QIO)” means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

(1883) “Radiological Services” mean those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, Hospital, or independent radiological facility.

(1894) “Recipient” means a person who is currently eligible for medical assistance (also known as a client).

(19085) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(19186) “Recoupment” means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

(19287) “Referral” means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

(19388) “Remittance Advice (RA)” means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(19489) “Request for Hearing” means a clear expression, in writing, by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(1950) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(1964) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

(1972) “Rural” means a geographic area that is 10 or more map miles from a population center of 30,000 people or less.

(1983) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse or abuse of Division requirements.

(1994) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(200195) “Service Agreement” means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(201196) “Sliding Fee Schedule” means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(202197) “Social Worker” means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(203198) “Speech-Language Pathologist” means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(204199) “Speech-Language Pathology Services” mean the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the

development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(205~~200~~) "State Facility" means a Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(206~~4~~) "Subparts (of a Provider Organization)" mean for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(207~~2~~) "Subrogation" means Right of the State to stand in place of the client in the collection of third party resources (TPR).

(208~~3~~) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(209~~4~~) "Surgical Assistant" means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(210~~05~~) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(211~~06~~) "Targeted Case Management (TCM)" means activities that will assist the client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by Allied Agency providers.

(212~~07~~) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

(213~~08~~) "Third Party Liability (TPL) or Third Party Resource (TPR)" means a medical or financial resource which, under law, is available and applicable to pay for medical services and items for a Authority client.

(214~~09~~) "Transportation" means Medical Transportation.

(215~~0~~) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

(216~~4~~) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services and regulatory programs for the elderly or the elderly and disabled.

(2172) “Type B AAA Unit” means a Type B AAA funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(2183) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.

(2194) “Urban” means a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

(22015) “Urgent Care Services” mean health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of unforeseen illness or injury.

(22116) “Usual Charge (UC)” means the lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(22217) “Utilization Review (UR)” means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(22318) “Valid Claim” means an invoice received by the Division or the appropriate Authority/Department office for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(22419) “Vision Services” mean provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

Stat. Auth.: ORS 413.042 414.065

Stats. Implemented: ORS 414.065

410-120-0025 Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence

(1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division), may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.651~~725~~ (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, the Division will construe them as much as possible to be complementary. In the event that Division policies, procedures, rules and interpretations may not be complementary, the Division will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to Division clients, including but not limited to authorization and delivery of service, or denials of authorization or services, the Division, clients, enrolled providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Division by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to Division clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, Division General Rules, 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to

Division clients are provided in Division General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in 410-141-0480 to 410-141-0520, and the provider rules applicable to the category of medical service;

(E) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Oregon Health Authority or Department of Human Services necessary to administer the State of Oregon's medical assistance programs, such as electronic data transaction rules in OAR 407-120-0100 to 407-120-0200; and

(F) The basic framework for provider enrollment in OAR 407-120-0300 through 407-120-0380 generally apply to providers enrolled with the Authority or Department, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by the Authority. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in subsections (A) – (E) of this section.

(b) For purposes of contract administration solely as between the Authority and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to Division clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supersede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

| 3-14-08 (T) 5-1-08 (P) 7-1-10 (Hk only) 9-1-10 (Hk) 3-1-11(Hk) 7-1-12

410-120-0250 Managed Care Organizations

(1) The ~~Oregon Health Authority (Authority)~~ provides some ~~Oregon Health Plan (OHP)~~ clients with ~~prepaid~~ health services, through contracts with a Prepaid Health Plan (PHP) or a Coordinated Care Organization (CCO) ; ~~also known as a Managed Care Organization (MCO). An MCO may be a Fully Capitated Health Plan (FCHP), Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO) or Physician Care Organization (PCO).~~

(2) The PHP or CCO ~~MCO~~ is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the PHP or CCO ~~MCO~~'s contract with the Authority and the OHP administrative rules governing PHPs and CCOs (OAR 410 division 141).

(3) All PHP or CCO ~~MCO~~s are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520, however, authorization criteria may vary between PHP or CCO ~~MCO~~s. It is the providers' responsibility to comply with the PHP or CCO ~~MCO~~'s Prior Authorization requirements or other policies necessary for reimbursement from the PHP or CCO ~~MCO~~, before providing services to any OHP client enrolled in a PHP or CCO ~~MCO~~.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025, 414.065, 414.651 ~~725~~ & 414.737

2-1-10 (Stat lines only)

7-1-10 (Hk)

9-1-10 (Hk)

3-1-11(Hk)

7-1-12

410-120-1260 Provider Enrollment

(1) This rule applies **only** to providers enrolled with, or seeking to enroll with **reimbursement from** the Division of Medical Assistance Programs (Division), ~~except as otherwise provided in OAR 410-120-1295 or 407.~~

(2) Providers ~~s~~Signing the P**rovider Enrollment A**greement **enclosed in the application package** constitutes agreement ~~by performing and billing providers~~ to comply with all applicable Division provider rules and federal and state laws and regulations.

~~(3) The Oregon Health Authority (Authority) and the Department of Human Services (Department) requires compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142.~~

(34) Non-payable provider is a provider who is issued a provider number for purposes of data collection or non-claims-use, such as but not limited to:

(a) ~~A performing provider is the provider of a service or item~~ Ordering or referring providers, whose only relationship with the Division is to order, refer, or prescribe services for Division clients;

(b) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;

(c) A provider contracted with a PHP or CCO;

(d) Nothing in this rule is meant to prevent an enrolled rendering provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the rendering provider is conducting electronic transactions, the Authority EDI rules will apply, consistent with section (6)(b) of this rule.

(4) A payable **billing** provider is a **provider who is issued a provider number for purposes of submission of health care claims for reimbursement.** A payable provider may be:

(a) The rendering provider:

~~(b) A performing provider is the provider of a service or item. A billing provider is an individual, agent, business, corporation, clinic, group, institution, or other entity who, in connection with the submission of claims to the Authority, receives or directs the payment (either in the name of the performing provider or the name of the billing provider) from the Authority on behalf of a rendering performing provider and has been delegated the authority to obligate or act on behalf of the performing provider;~~

(c) For the purposes of this rule a payable provider will be referred to as a provider.

(5) When receiving or directing payment on behalf of the rendering provider, the provider must:

(a) Meet one of the following standards as applicable:

(A) A corporate or business entity who, under one of the relationships authorized by 42 CFR 447.10(g), has the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider;

(B) Any other contracted billing agent or billing service that has enrolled with the Division to provide services in connection with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f)

(b) Maintain, and make available to Division, upon request, records indicating the provider's relationship with the rendering provider(s). These include:

(A) Identification of all rendering providers for whom they bill, or receive or direct payments. The provider must keep the identification information current for each rendering provider (at the time of enrollment or within 30 days of any change):

~~(ia) A billing provider is responsible for identifying to the Division and keeping current the identification of all performing providers for whom they bill, or receive or direct payments. This identification must include the providers' names, date of birth, address, Division Authority provider numbers, NPIs, and either the performing rendering provider's Social Security Number (SSN) or at the Divisions option the Employer Identification Number (EIN); .The SSN or EIN of the performing provider cannot be the same as the Tax Identification Number of the billing provide~~

(B) This information is necessary for the Division to timely process and pay claims:†

(c) Prior to submission of any claims or receipt or direction of any payment from the Division, signed confirmation from the rendering provider(s) that the billing entity or provider has been authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be maintained in the provider's files for at least five years, following the submission of claims or receipt or direction of funds from the Division.

(6) In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements for providers:

(a) ~~T~~the Division Authority requires billing providers to be enrolled consistent with the provider enrollment process described this in section (7) of this rule: ~~. A performing provider's use of a billing provider that falls within the definition of a billing provider but that is not enrolled with the Division will result in denial of claims or payment;~~

(b) If the performing provider uses electronic media to conduct transactions with the Division Authority, or authorizes a non-payable billing provider †(e.g, billing service or billing agent) to conduct such electronic transactions, the performing provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943407-120-0100 through 943407-120-0200. Enrollment as a performing or billing

provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims...

(75) To be enrolled and able to bill as a provider, an individual or organization must:

(a) ~~M~~meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations and rules;

(b), ~~and must~~ ~~C~~comply with all Oregon statutes and regulations for provision of Medicaid and ~~S~~CHIP services;

(c). If providing services ~~In addition, Providers of services~~ within the State of Oregon, ~~must~~ have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services;-

(d) ~~An Indian Health~~ Service facility meeting enrollment requirements will be accepted on the same basis as any other qualified provider. However, when State licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

(86) An individual or organization that is currently subject to sanction(s) by the Division, another state's Medicaid program, or federal government is not eligible for enrollment (see OAR 410-120-1400, 943~~407~~-120-0360, Provider Sanctions).

(9) Required information: ~~In addition, All individuals or organizations that apply for enrollment~~ Providers must meet the following requirements before the Division can issue or renew a provider number, or at any time upon written request by the Division: ~~are subject to the following~~

(a) Disclosure requirements, ~~Before the Authority issues or renews a provider number for provider services, or at any time upon written request by the Authority,~~ ~~T~~he provider must disclose to the Division ~~Authority~~:

(A) ~~The~~ identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP program ~~since~~ in the last 10 years ~~inception of those programs~~;

(Bb) If the ~~A Medicaid~~ provider ~~that~~ is an entity other than an individual practitioner or group of practitioner's, ~~must disclose certain information about ownership and control of the entity~~:

(iA) The name, date of birth, ~~and~~ address and tax identification number of each person with an ownership or control interest in the provider, or in any subcontractor in which the provider has a direct or indirect ownership interest of 5 percent or more. When disclosing tax identification numbers:;

(I) For corporations, use the federal Tax Identification Number;

(II) For individuals in a solo practice or billing as an individual practitioner, use the Social Security Number (SSN);

(III) All other providers use the Employer Identification Number (EIN);

(IV) The SSN or EIN of the rendering provider cannot be the same as the Tax Identification Number of the billing provider;

(V) ~~Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041~~, SSN's and EIN's provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities;

(iiB) Whether any of the persons so named:

(I) ~~Is~~ related to another as spouse, parent, child, sibling or other family members by marriage or otherwise; and

(II~~C~~) Has an ownership or control interest in ~~The name of~~ any other ~~disclosing~~ entity ~~in which a person with an ownership or control~~

~~interest in the disclosing entity also has an ownership or control interest;~~

~~(C6) All providers must agree to furnish to the Authority or to the U.S. Department of Health and Human Services on request, information related to certain business transactions:~~ A provider must submit, within 35 days of the date of a request, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request;.

~~(d) The Division may refuse to enter into or renew a provider's enrollment agreement, or contract for provider services, with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid SCHIP or the Title XX services program; (e) The Division may refuse to enter into or may terminate a provider enrollment agreement, or contract for provider services, if it determines that the provider did not fully and accurately make any disclosure required under this section (6) of this rule.~~

~~(b7) Provider screening and enrollment requirements: The provider must submit the following information to the Division:~~**Enrollment of performing providers. A Division-assigned performing provider number will be issued to an individual or organization providing covered health care services or items upon:**

(A) For non-payable providers, a complete Non-Paid Provider Enrollment Request**Completion of the application and submission of the required attachment, disclosure documents, and provider agreement.**

(B) For payable providers, a complete Provider Enrollment Request, Provider Enrollment Attachment, Disclosure Statement and Provider Enrollment Agreement;

~~The signing of the provider application by the performing provider or a person authorized by the performing provider to legally bind the organization or individual to compliance with these rules;~~

(c) Consent to criminal background check when required;

(d) Verification of licensing or certification. Loss of the appropriate licensure or certification will result in immediate disenrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

~~(d) Approval of the application package by the Division or the Authority unit responsible for enrolling the provider.~~

(e) Required updates: Enrolled providers must notify the Division in writing of material changes in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to those listed in this subsection;

(A) Failure to notify the Division of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual rendering providers may result in the imposition of a \$50 fine;

(i) If the Division notifies a provider about an error in their Federal Tax Identification, including Social Security Numbers or Employer Identification Numbers for individual rendering providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division notice.

(ii) Failure to comply with this requirement may result in the Division imposing a fine of \$50 for each such notice. Federal Tax Identification requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(B) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;

(C) In the event of bankruptcy proceedings, the provider must immediately notify the Division Administrator in writing;

(D) Claims submitted by, or payments made to, providers who have not furnished the notification required by this rule or to a provider that has failed to submit a new application as required by the Division under this rule may be denied or recovered.

(108) ~~Performing~~ Rendering providers may be enrolled retroactive to the date services were provided to a Division client only if:

(a) The provider was appropriately licensed, certified and otherwise met all Division requirements for providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date the application for provider status was received by the Division as evidenced by the first date stamped on the paper claim(s) submitted with the application materials for those services, either manually or electronically;

(c) The Division reserves the right to retroactively enroll the provider prior to the 12-month period in (b) based upon extenuating circumstances outside the control of the provider, consistent with federal Medicaid regulations, and with approval of the Division's Provider Enrollment ~~Services~~ Unit Manager.

(119) Provider numbers:

(a) Oregon Medicaid provider number: The Division issues ~~issuance of a Authority-assigned~~ provider numbers to establish ~~es~~ an ~~enrollment of an~~ individual or organization's enrollment as an Oregon Medicaid provider;

(A) This number designates ~~for the~~ specific category-(ies) of services covered by the Division Provider Enrollment Attachment ~~application~~. For example, a pharmacy provider number applies to pharmacy services but not to durable medical equipment, which requires a separate provider application attachment and establishes a separate Oregon Medicaid ~~Authority-assigned~~ provider number.

(B) For providers not subject to NPI requirements, this number is the provider identifier for billing the Division;

(b) National Provider Identifier (NPI) and taxonomy: The Authority requires compliance with NPI requirements in 45 CFR Part 142. For providers subject to NPI requirements:

(A) The NPI and taxonomy codes are the provider identifier for billing the Division;

(B) Currently enrolled providers that obtain a new NPI are required to update their records with the Division's Provider Enrollment Unit;

(C) Provider applicants must obtain an NPI and include it in their provider enrollment request to the Division.

~~(10) Required updates: A provider is responsible for providing, and continuing to provide, to the Authority accurate, complete and truthful information concerning their qualification for enrollment. An enrolled provider must notify the Authority in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to a change in any of the following information: address, business affiliation, licensure, certification, NPI, or Federal Tax Identification Number, or if the provider's ownership or control information changes; or if the provider or a person with an ownership or control interest, or an agent or managing employee of the provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP services program. The provider must notify the Division of changes in any of this information in writing within 30 calendar days of the change.~~

~~(a) Failure to notify the Division of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual Performing providers may result in the imposition of a \$50 fine;~~

~~(b) In addition to section(10) (a) of this rule, if the Division notifies a provider about an error in Federal Tax Identification Number including Social Security Numbers or Employer Identification Numbers for individual performing providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division notice. Failure to comply with this requirement may result in the Division imposing a fine of \$50 for each such notice. Federal Tax Identification Number requirements described in this rule refer to any such requirements established by the Internal Revenue Service;~~

~~(c) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;~~

~~(d) Claims submitted by, or payments made to, providers who have not furnished the notification required by this rule or to a provider that has failed to submit a new application as required by the Division under this rule may be denied or recovered.~~

(1244) Enrollment of Out-of-State providers: Providers of services outside the State of Oregon will be enrolled as a provider under section (97) of this rule if they comply with the requirements of section (97) and under the following conditions:

(a) The provider is appropriately licensed or certified and meets standards ~~and is enrolled within the provider's state~~ for participation in the ~~state's~~ Medicaid program. Disenrollment or sanction from ~~the~~ other state's Medicaid program, or exclusion from any other federal or state health care program is a basis for disenrollment, termination or suspension from participation as a provider in Oregon's medical assistance programs;

(b) Noncontiguous Out-of-State pharmacy providers must be licensed by the Oregon Board of Pharmacy to provide pharmacy services in Oregon. In instances where clients are out of the state due to travel or other circumstances that prevent them from using a pharmacy licensed in Oregon, and prescriptions need to be filled, the pharmacy is required to be licensed in the State they are doing business where the client filled the prescription, and must be enrolled with the Division Authority in order to submit claims. Out-of-state internet or mail order, except the Division Authority mail order vendor, prescriptions are not eligible for reimbursement;

(c) The provider bills only for services provided within the provider's scope of licensure or certification;

(d) For noncontiguous out-of-State providers, the services provided must be authorized, in the manner required under these rules for out-of-State Services (OAR 410-120-1180) or other applicable Authority rules:

(A) For a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) clients.

(e) The services for which the provider bills are covered services under the Oregon Health Plan (OHP);

(f) Facilities, including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities, will be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by the State of Oregon;

(g) Out-of-State providers may provide contracted services per OAR 410-120-1880.

(h) Out-of-state billing providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 943-120-0320(15)(f).

~~(12) Enrollment of billing providers:~~

~~(a) An individual or business entity that, in connection with the submission of claims to the Division and receives or directs the payments from the Division on the behalf of a professional performing provider (e.g., physician, physical therapist, speech therapist) must be enrolled as a billing provider with the Division and meet all applicable federal and state laws and regulations. A billing agent or billing service submitting claims or providing other business services on behalf of a performing provider but not receiving payment in the name of or on behalf of the performing provider does not meet the requirements for billing provider enrollment and is not eligible for enrollment as a billing provider;~~

~~(b) Billing providers must complete an application for enrollment and submit all required documentation including a provider enrollment agreement, consistent with the provider enrollment process described in subsection (7), to obtain a Authority-assigned provider number. A Authority-assigned billing provider number will be issued only to billing providers that have a contract with an enrolled performing provider to provide services in connection with the submission of claims and receive or direct payments on behalf of the performing provider, and that have met the standards for enrollment as a billing provider including one of the following as applicable:~~

~~(A) A corporate or business entity related to the performing provider under one of the relationships authorized by 42 CFR 447.10(g) may have the authority to submit the performing provider enrollment application and supporting documentation on behalf of the performing provider. Such entities with the authority to provide services in connection with the submission of claims and obtain or direct~~

~~payment on behalf of the performing provider must enroll as a billing provider;~~

~~(B) Any other contracted billing agent or billing service (except as are described in section (12)(b) (A) of this rule) that has authority to provide services in connection with the submission claims and to receive or direct payment in the name of the performing provider pursuant to 42 CFR 447.10(f). Such entities with the authority to obtain or direct payment on behalf of the performing provider in connection with the submission of claims must enroll as a billing provider;~~

~~(C) These billing provider enrollment requirements do not apply to the staff directly employed by an enrolled performing provider, rather than pursuant to a contractual arrangement. Nothing in this rule is meant to prevent an enrolled performing provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the performing provider is conducting electronic transactions, the Authority EDI rules will apply, consistent with section (4) of this rule.~~

~~(c) A billing provider must maintain, and make available to Division, upon request, records indicating the billing provider's relationship with the provider of service;~~

~~(d) Prior to submission of any claims or receipt or direction of any payment from the Division, the billing provider must obtain signed confirmation from the performing provider that the billing provider has been authorized by the performing provider to submit claims or receive or direct payment on behalf of the performing provider. This authorization, and any limitations or termination of such authorization, must be maintained in the billing provider's files for at least five years, following the submission of claims or receipt or direction of funds from the Division;~~

~~(e) The billing provider fee must not be based on a percentage of the amount billed or collected or whether or not they collect the subject's payment (42 CFR 447.10(f)).~~

~~(f) If the billing provider is authorized to use electronic media to conduct transactions on behalf of the performing provider, the performing provider must register with the Authority as a trading partner and authorize the billing provider to act as an EDI submitter, as required in the Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Enrollment as a billing provider does not provide that authority. If the performing provider uses electronic media to conduct transactions, and authorizes a billing agent or billing service that is not authorized to receive reimbursement or otherwise obligate the performing provider, the billing agent or billing service does not meet the requirements of a billing provider. The performing provider and billing agent or billing service must comply with the Authority EDI rules, OAR 407-120-0100 through 407-120-0200.;~~

~~(g) Out-of-state billing providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 407-120-0320(15)(f).~~

~~(h) All billing providers are required to notify the Division, at the time of enrollment or within 30 days of any change, of the names of all performing providers and their Authority provider number, NPI number and the Social Security Number or Employer Identification Numbers of the performing providers. The performing provider's SSN or EIN is required pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041. SSN's and EIN's provided pursuant to this authority are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. In addition, this information is necessary for the Authority to timely process and pay claims.~~

(13) Absentee Physicians **Utilization of locum tenens:** When a substitute physician is retained to take over another physician's professional practice while he or she is absent or unavailable, the following shall apply:

(a) The Division recognizes that absentee physicians may retain substitute physicians as a locum tenens or as part of a reciprocal billing arrangement. For purposes of this rule:

(ia) ~~For purposes of this rule, a~~ A locum tenens means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.;

(ii) A locum tenens cannot be retained to take over a deceased physician's professional practice without becoming enrolled with the Division;

(iii) A reciprocal billing arrangement means a substitute physician retained on an occasional basis;

(b) Locum tenens or substitute physicians ~~Locum tenens~~ are not required to enroll with the Division ~~Authority~~; however, the Division ~~Authority~~ may enroll ~~locum tenens~~ such providers at the discretion of the Division's Provider Enrollment ~~services~~ manager if ~~that~~ provider submits all information required for provider enrollment as described in Section (11) of this rule; ~~complete enrollment application, especially in areas of the State underserved with medical providers.~~

(c) In no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;

(de) The absentee physician must be an enrolled Division ~~Authority~~ provider and must bill with their individual Division ~~Authority~~ assigned provider number and receive payment for covered services provided by the substitute ~~locum tenens~~ physician;

(A) ~~Services~~ provided by the locum tenens must be billed with a modifier Q6:

(B) Services provided in a reciprocal billing arrangement by the substitute physician must be billed with a modifier Q5;

(CA) In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection, and are services for which the absentee physician is authorized to submit a claim;

(DB) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.

~~(14) Reciprocal billing arrangements:~~

~~(a) For purposes of this rule, reciprocal billing arrangements are similar in nature to a locum tenens in that a substitute physician is retained to take over another physician's professional practice on an occasional basis if the regular physician is unavailable (absentee physician);~~

~~(b) Providers with reciprocal billing arrangements are not required to enroll with the Authority; however, in no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;~~

~~(c) The absentee physician must be an enrolled Authority provider and must bill with his or her individual Authority-assigned provider number and receive payment for covered services provided by the substitute physician. The absentee physician identifies the services provided by the substitute physician by using modifier Q5:~~

~~(A) In entering the Q5 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection, and are services for which the absentee physician is authorized to submit a claim.~~

~~(B) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.~~

(ed) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the practice or ~~Billing provider~~ or group name.

(f) Nothing in this rules prohibits physicians sharing call responsibilities from opting out of the ~~reciprocal billing~~ (substitute provider) arrangement(s) described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled ~~performing~~ providers and as long as duplicate claims for services are not submitted.

(145) Provider termination:

(a) The provider may terminate enrollment at any time. The request must be in writing, and signed by the provider. The notice shall specify the Division ~~Authority~~ assigned provider number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;

(b) The Division ~~Authority~~ may ~~provider~~ terminateions or suspendions providers when a provider fails to meet one or more of the requirements governing a provider's participation in Oregon's medical assistance programs, such as but not limited to: ~~may be for, but are not limited to the following reasons:~~

(A) Breaches of provider agreement;

(B) Failure to submit timely and accurate information as requested by the Division;

(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;

(D) Failure to permit access to provider locations for site visits;

~~(E) Failure to comply with Federal or State~~the statutes and, regulations, or ~~and~~ policies of the Division ~~Authority, Federal or State regulations~~ that are applicable to the provider;-

~~(F) No~~When no claims have been submitted in an 18-month period. The provider must reapply for ~~enrollment~~enrollment;-

(G) Any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP or the Title XX services program in the last 10 years;

(H) Failure to fully and accurately make any disclosure required under this section (11) of this rule.

~~(15) When a provider fails to meet one or more of the requirements governing a provider's participation in Oregon's medical assistance programs, the provider's Authority-assigned provider number may be immediately suspended. Suspended or terminated~~The providers are ~~is~~ entitled to appeal the decision as a contested case hearing pursuant to OAR~~as outlined in~~ 410-120-1600 and~~through~~ 410-120-1860~~to determine whether the provider's Authority-assigned number will be revoked.~~

~~(16) The provision of health care services or items to~~Division ~~Authority~~ clients is a voluntary action on the part of the provider. Providers are not required to serve all Division ~~Authority~~ clients seeking service.

~~(18) In the event of bankruptcy proceedings, the provider must immediately notify the Authority Administrator in writing.~~

~~[Publications: Publications referenced are available from the agency.]~~

~~Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110~~
~~Stats. Implemented: ORS 414.025 & 414.065~~

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065

12-01-08

7-1-10 (Hk and Stats)

9-1-10 (Hk)

7-1-11 (HK)

7-1-12

410-120-1340 Payment

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients. Any contracted billing agent or billing service submitting claims on behalf of a provider but not receiving payment in the name of or on behalf of the provider does not meet the requirements for billing provider enrollment. If billing agents and billing services intend to submit electronic transactions they must register and comply with the Oregon Health Authority (Authority) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Division reimbursement for services may be subject to review prior to reimbursement.

(2) The Division (Division of Medical Assistance Programs or another Division within the Authority) that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(3) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules:

(4A) Amount billed may not exceed the provider's "usual charge" (see definitions);

(5B) The Division's maximum allowable rate setting process uses the following methodology. The rates are updated periodically and posted on the Authority web site at

http://www.oregon.gov/OHA/Department/healthplan/data_pubs/feeschedule/main.shtml:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an ~~Relative Value Unit (RVU)~~ weight, ~~and reflecting services not typically performed in a facility~~, the Division shall ~~continue to~~ use the 2010 Transitional ~~Non-Facility~~ Total RVU weights published in the Federal Register, Vol. 74, November 25, 2009 with technical corrections published Dec. 10, 2009, to be effective for dates of services on or after ~~beginning~~ January 1, 2011.

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight shall be adopted;

(B) For ~~CPT/HCPCS codes for~~ professional services typically performed in a facility the Transitional Facility Total RVU weight shall be adopted;

(b) DMAP applies the following conversion factors:

(Ai) ~~\$41.61 The conversion factor~~ for labor and delivery codes (59400-59622) ~~is \$41.61~~;

(ii) ~~CPT codes 92340-92342 and 92352-92353 remain at a flat rate of \$26.81~~;

(Biii) ~~\$27.82 The conversion factor~~ for pPrimary care providers and services ~~is 27.82~~. A current list of pPrimary care CPT-, HCPCS and provider specialty codes is available at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml

~~The document dated:~~

~~(I) August 1, 2011, is effective for dates of service on or after August 1, 2011.~~

(Civ) ~~\$26.00 for a~~All remaining RVU weight based CPT/HCPCS codes ~~have a conversion factor of \$26.00~~;

(D) \$26.81 for vision codes (92340-92342 and 92352-92353) regardless of the RVU.

(6) Other non RVU based rates:

(a**B**) Surgical assist reimburses at 20% of the surgical rate;

(~~Cb~~) \$21.20 is ~~t~~The base rate for anesthesia service codes ~~s~~ 00100-01996.
~~is \$ 21.20 and is~~ The rate is based on per unit of service;

(~~cD~~) Clinical lab codes are priced at 70% of the Medicare clinical lab fee schedule;

(~~dE~~) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of the Medicare fee schedule;

(~~eF~~) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(~~fG~~) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling.;

(~~ge~~) Individual provider rules may specify reimbursement rates for particular services or items.

(74) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services Program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, shall not exceed any upper limits established by federal regulation.

(85) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(96) Payment rates for in-home services provided through Department of Human Services (Department) Seniors and People with Disabilities Division (SPD) will not be greater than the current Division rate for nursing facility payment.

(107) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by ~~SPD~~-APD for out-of-state nursing facilities.

(118) The Division shall not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(129) The Division shall not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules, (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules, (chapter 410, division 129 and 131);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Program administrative rules, (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Program administrative rules, (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services Program rules, (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Program administrative rules, (chapter 410, division 122).

(130) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment will not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(141) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. The Division's payment cannot exceed the co-insurance and deductible amounts due;

(b) The Division pays the Division allowable rate for Division covered services that are not covered by Medicare.

(152) For clients with third-party resources (TPR), the Division pays the Division allowed rate less the TPR payment but not to exceed the billed amount.

(16~~3~~) The Division payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(17~~4~~) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742, 414.743

8-1-11 (T) 1-1-12 (P)

410-120-1395 Program Integrity

(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity. These rules describe program integrity actions related to provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled provider for covered, medically appropriate services provided to an eligible client according to the client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

- (a) Medical review and prior authorization processes, including all actions taken to determine the medical appropriateness of services or items;
- (b) Provider obligations to submit correct claims;
- (c) Onsite visits to verify compliance with standards;
- (d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;
- (e) Provider credentialing activities;
- (f) Accessing federal Department of Health and Human Services database (exclusions);
- (g) Quality improvement activities;
- (h) Cost report settlement processes;
- (i) Audits;
- (j) Investigation of fraud or prohibited kickback relationships;
- (k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities.

(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360, Requirements for Financial, Clinical and Other Records, in the General Rules Program, the Oregon Health Plan administrative rules, and the rules applicable to the service or item.

(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Division of Medical Assistance Program's (Division) rules and the generally accepted standards of a provider's field of practice or specialty:

(a) Authority, Department staff or designee; or

(b) Medical utilization and review contractor; or

(c) Dental utilization and review contractor; or

(d) Federal or state oversight authority.

(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with Division rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related provider and Hospital billings will also be denied or subject to recovery.

(5) When the Authority determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(6) The Authority may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

(7) The Authority must notify HHS-OIG within 20 working days of any disclosures from the date it receives the information, or takes any adverse action to limit the ability of an individual or entity to participate in its program as provided in 42 CFR 1002.3(b). This includes, but is not limited to, suspension, denials, terminations, settlement agreements and situations

where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

(8) When the Authority initiates an exclusion under § 1002.210, it must notify the individual or entity subject to the exclusion and other state agencies, the state medical licensing board, the public, beneficiaries, and others as provided in § 1001.2005 and § 1001.2006.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

2-1-10

7-1-10 (Hk only)

9-1-10 (Hk)

3-1-11 (Hk)