

Health Services
Office of Medical Assistance Programs

Joan M. Kapowich, Manager
OMAP Program and Policy Section

Authorized Signature

Number: OMAP-IM-04-137

Issue Date: 11/19/04

Topic: Medical Benefits

Subject: Expanded Rural Pharmaceutical Access, Dispensing Providers Enrollment

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): DHS staff and others identified on the SPD, CAF, OMHAS and OMAP transmittal lists |

Message: The Legislature approved expanding pharmacy access to rural areas by allowing certified professionals to dispense prescription drugs. The attached enrollment instructions and forms have been mailed to qualifying providers this week.

If you have any questions about this information, contact:

Contact(s):	Sharon Hill, OMAP Policy Analyst		
Phone:	503-945-6957	Fax:	
E-mail:	Sharon.k.hill@state.or.us		



Oregon

Theodore R. Kulongoski, Governor

Department of Human Services

Health Services

Office of Medical Assistance Programs

500 Summer Street NE, E35

Salem, OR 97301-1077

Voice (503) 945-5772

FAX (503) 373-7689

TTY (503) 378-6791

November 17, 2004

To: Rural Health Clinics (RHCs)

From: Joan M. Kapowich, Manager
OMAP Program and Policy Section



Subject: Requirements for Dispensing Urgent/Emergency Drugs in Rural Areas

Effective: July 1, 2004 (retroactive)

This memo outlines the OMAP enrollment requirements for RHCs that plan to use dispensing practitioners to dispense medications to OHP clients in rural areas in accordance with ORS 414.325(7), attached.

Dispensing practitioners must be appropriately certified by either the Oregon Board of Nursing, the Oregon Board of Medical Examiners or by the certifying agencies in contiguous states. Drug dispensing is limited to “urgent medical conditions” using manufacturer pre-packaged and pharmacist re-packaged medications as defined by the dispensing provider’s scope of practice.

In order for your clinic to be reimbursed from OMAP for drugs dispensed to OHP clients under the limited statutory conditions, you must have an OMAP **pharmacy** provider number. This is in addition to any other provider number(s) you may have already.

In order to enroll as a pharmacy provider, you must provide, in writing, the following information:

- List the licensed practitioners in your employ who have appropriate certification and will be dispensing drugs on behalf of your clinic.
- Include a copy of each practitioner’s certification to dispense drugs.
- Send a completed Rural Dispensing Provider enrollment form, (OMAP 3115R enclosed).
- Send a copy of the IRS letter confirming your tax ID number.

-over-

“Assisting People to Become Independent, Healthy and Safe”
An Equal Opportunity Employer

PN 04-124

Send all the information to:

Attn: Dispensing
DHS, OMAP Provider Enrollment
500 Summer St. NE, E44
Salem, OR 97301-1079

Once you are enrolled with a pharmacy provider number, all pharmacy claims must use your **pharmacy** provider number on the drug claim. **If you use any other provider number, OMAP will deny the pharmacy claim.**

OMAP will send a separate claims packet to those who enroll as Rural Dispensing Providers, explaining the billing process.

You must bill all drugs dispensed in accordance with OMAP pharmacy program rules (OAR 410-121) and billing procedures.

OMAP pharmacy administrative rules, prior authorization and billing information are available online at <http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy> or in hardcopy by calling 1-800-527-5772.

Questions? Call OMAP Provider Enrollment: 1-800-422-5047

414.325 Prescription drugs; use of legend or generic drugs; prior authorization.

(1) As used in this section, “legend drug” means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner’s care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) The department shall pay only for drugs in the generic form if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards, unless an exception has been granted by the department.

(4) An exception must be applied for and granted before the department is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(5) Notwithstanding subsections (1) to (4) of this section, the department is authorized to:

(a) Withhold payment for a legend drug when federal financial participation is not available; and

(b) Require prior authorization of payment for drugs that the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as approved by the federal Food and Drug Administration to treat mental illness, HIV and AIDS, and cancer.

(7)(a) The department shall pay a rural health clinic for a legend drug prescribed and dispensed under this chapter by a licensed practitioner at the rural health clinic for an urgent medical condition if:

(A) There is not a pharmacy within 15 miles of the clinic;

(B) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(C) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(b) As used in this subsection, “urgent medical condition” means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(8) Notwithstanding ORS 414.334, the department may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period. [1977 c.818 §§2,3; 1979 c.777 §45; 1979 c.785 §3; 1983 c.608 §2; 1999 c.529 §1; 2001 c.897 §5; 2003 c.14 §190; 2003 c.91 §1; 2003 c.810 §20]

Note: The amendments to 414.325 by section 6, chapter 897, Oregon Laws 2001, become operative January 2, 2007. See section 7, chapter 897, Oregon Laws 2001. The text that is operative on and after January 2, 2007, including amendments by section 191, chapter 14, Oregon Laws 2003, section 2, chapter 91, Oregon Laws 2003, and section 21, chapter 810, Oregon Laws 2003, is set forth for the user’s convenience.

INSTRUCTIONS

OMAP PROVIDER APPLICATION - RURAL DISPENSING PROVIDERS

Field	Instructions
1	Rural Health Clinics: If you have certified practitioners to dispense medications for urgent medical conditions according to ORS 414.325(7), enter the complete name of your business.
2	Enter your complete office/business address (<i>physical location of office</i>).
3	If you wish to receive payment and correspondence at another address or a PO Box, enter the complete address here. If this is blank, all mail will be posted to the address in field 2.
4	Enter your business telephone number, including area code.
5	If available, enter your business office FAX number, including area code.
6	If available, enter your email address.
7	Enter your Employer Identification Number or your Social Security Number. Provider must enter Social Security Number or federal tax ID number, pursuant to 42 CFR §433.37, ORS 305.385, OAR 125-20-410(3) and OAR 150-305.100, for the administration of state, federal and local tax laws. Attach a copy of your IRS letter (if applicable).
8	Enter the name of the county in which your practice is located.
9	Indicate the proprietary nature of your business by checking the appropriate box. Please explain when "other" is indicated, using the back of the application.
10	If you are an eligible provider under Medicare (<i>Title XVIII A or B</i>), enter your Medicare provider number. Attach a copy.
11	Enter your Drug Enforcement Agency (DEA) number (<i>if applicable</i>).
12	Enter your CLIA number. Attach a copy of your CLIA certification letter (if applicable).
13	Out-of-Oregon providers only: Enter your Medicaid provider number for the state in which your pharmacy is located.
14	Out-of-Oregon providers only: Enter the name and telephone number of the Medicaid office which can confirm your enrollment.
15	For each professional who dispenses for your clinic, enter the a) dispensing certification number, b) related certification board, and c) Professional OMAP provider number (<i>if applicable</i>). Attach a copy of the dispensing certification for each practitioner listed.
16	Add explanation or other information here.

NOTE: The provider is required to notify OMAP in writing within 30 days of any of the following changes in connection with a certified practicing dispenser:

- If a certified dispensing practitioner leaves;
- If a certified dispensing practitioner is added;
- If a certified dispensing practitioner's authority to dispense medications is suspended or revoked by the practitioner's licensing board.

Payments made to providers who have not furnished such notification may be recovered.

Applications must be signed and dated by the Provider.

- OMAP will not accept stamped signatures.**
- OMAP will return incomplete applications.**

OMAP PROVIDER APPLICATION – RURAL DISPENSING PROVIDERS

(Shaded areas for OMAP use only)			(Read instructions before completing)					(Print or Type)							
1 Business Name												Name Ind P			
2 Physical Location Address						3 Mailing Address (if different)									
City		State		ZIP		City		State		ZIP					
4 Area Code - Phone # _____				IRS/SSN	7 IRS/SSN # (Attach copy of IRS letter)			ST	8 County		LOC				
5 Area Code - FAX # _____															
6 Email _____															
9 Check one:			<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership		<input type="checkbox"/> Other (explain on reverse)		Rec Type 0	Prov Type PH	Bulk Add Ind	Bulk # 1	Obj Class	Status / Eff Date AA:	FICA Deduct IND 2		
Billing Numbers				10 Medicare # (Attach copy)				11 DEA #			12 CLIA # (Attach copy of cert letter)				
Lab Certs															
010	100	110	115	120	130	140	150	200	210	220	300	310	320	330	340
350	400	500	510	520	530	540	550	560	600	610	620	630	800	900	
Out of State Providers complete items 13-14															
13 Medicaid Provider Number (in state where practice is located)						14 Medicaid Contact						Area Code - Phone			
Professionals Certified to Dispense Medications complete item 15															
15a. Dispensing Certification # (attach copy of dispensing certification)				15b. Certification Authority (check one per number):				15c. Professional Provider #							
				Board of Medical Examiners		State Board of Nursing									

16 Add explanation or other information here.

Medical Provider Enrollment Agreement

This Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services, Office of Medical Assistance Programs (“OMAP”) and _____ (“Provider”) regarding payment by OMAP for medical care, services, equipment and/or supplies furnished by Provider to persons eligible for medical assistance in Oregon (“Recipients”).

A. **Services** When providing medical care, services, equipment and/or supplies to Recipients for which payment is requested from OMAP, the Provider shall adhere to OMAP rules. “OMAP Rules” means the OMAP General Rules, Oregon Health Plan rules, and provider guide(s) applicable to the Provider’s service category, all as amended from time to time.

Provider shall perform all services which are paid for by OMAP under this Enrollment Agreement as an independent contractor. Provider is not an “officer”, “employee”, or “agent” of OMAP, as those terms are used in ORS 30.265.

B. **Payment** Subject to the requirements of the OMAP Rules and the terms and conditions of this Enrollment Agreement, OMAP agrees to make payment to Provider for covered medical care, services, equipment and/or supplies to Recipients. Payment is determined using the procedures described in the OMAP Rules. Except as provided in the OMAP Rules, OMAP will not make payment to anyone other than Provider. By accepting payment, Provider certifies that it has complied with all OMAP Rules. Except as otherwise provided in the OMAP Rules, Provider accepts, as payment in full for a claim, the amount paid by OMAP for that claim.

OMAP has sufficient funds currently available and authorized to make payments under this Enrollment Agreement within OMAP’s biennial budget. Payment for services performed after this biennium is contingent on OMAP receiving from the Oregon Legislative Assembly appropriations or other expenditure authority sufficient to allow OMAP, in its reasonable administrative discretion, to continue to make payments.

C. **Recordkeeping; Access; Confidentiality of Recipient's Records** Provider is responsible for the completion and accuracy of (1) financial and clinical records and all other documentation regarding the specific care, items or services for which payment has been requested, and (2) all claims submitted by or on behalf of Provider.

Provider shall furnish requested documentation to OMAP, the state Medicaid fraud unit, the Oregon Secretary of State’s Office and the federal government, and their duly authorized representatives to examine, audit and make copies.

A Recipient’s records are confidential and may be given only to the Recipient, or to others with the Recipient’s consent, or for purposes directly connected with the administration of the public assistance laws.

D. **Compliance with applicable laws** Provider shall comply with federal, state and local laws and regulations applicable to this Enrollment Agreement, including but not limited to OAR 410-120-1380. OMAP’s obligations under this Enrollment Agreement are conditioned upon Provider’s compliance with provisions of ORS 279.312, 279.314, 279.316, 279.320, and 279.555, as amended from time to time, which are incorporated in this agreement. Provider is responsible for all Social Security payments and federal or state taxes applicable to payments under this Enrollment Agreement.

E. **Termination** Provider or OMAP may terminate this Enrollment Agreement at any time by written notice to the other by certified mail, return receipt requested. This notice shall specify the effective date of termination. Provider shall send any termination notice to OMAP to: Provider Enrollment, OMAP-PRU, 500 Summer St. NE, Salem, OR 97310-1014.

F. Eligibility and Continued Participation; Provider sanctions and payment recovery Eligibility and continued participation in the Medical Assistance Program is conditioned on Provider's execution and delivery of the application and required certification, and the continued accuracy of that information. The information disclosed by Provider may be subject to verification. This information will be used for purposes related to the administration of the Medical Assistance Program.

Failure to comply with the terms of this Enrollment Agreement or the OMAP Rules or failure of the application or certificate to be accurate in any respect may result in sanctions and/or payment recovery pursuant to OAR 410-120-1400 to 410-120-1540, subject to Provider appeal rights described in OAR 410-120-1560 to 410-120-1840.

PROVIDER: By signing this Enrollment Agreement you acknowledge that you have read the Enrollment Agreement, understand the terms of the Agreement, and agree to be bound by the terms and conditions of the Agreement.

Signature of Provider or Authorized Business Representative

Date

Title of Business Representative

For OMAP Only

STATE OF OREGON, acting by and through the Department of Human Services, Office of Medical Assistance Programs.

By: _____

Title: _____

Date _____

PROVIDER CERTIFICATION

Instructions

- *If you are enrolling as an individual performing Provider (even if you are an employee or a member of a group practice), please answer question number five (5), parts (a), (b), and (c); read the certification statement carefully, and sign this part of the enrollment application.*
- *If you are enrolling as a business agent or group practice, please answer all questions, read the certification statement carefully, and have an authorized representative of the business or group sign this part of the enrollment application.*
- *If you need additional room to complete your answers, please use an additional sheet of paper.*

1. Identify each person or entity with an ***ownership or control interest*** in the business or group practice:

Definition: A person or entity “with an ownership or control interest” in the business or group practice is anyone who

- (a) has directly or indirectly a 5% or more ownership interest in the business or group;
 - (b) is the owner of a 5% or greater interest in any note or other obligation which is secured in whole or in part by any of the property or assets of the business or group;
 - (c) is an officer or director of the business or group if the business or group is a corporation; or
 - (d) is a partner in the business or group if the business or group is a partnership.
-
-

2. Identify any person who is an ***officer, director, agent or managing employee*** of the business or group practice:

3. Identify any person listed in (1) or (2) above who was employed during the last twelve (12) months in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier providing reimbursement to the business or group practice:

or, No one has worked for a fiscal intermediary or carrier during the last twelve months.

4. Identify any person listed in (1) or (2) above who is related to any other person listed in (1) or (2) above as a spouse, parent, child or sibling:

or, No persons are related to another.

5. If you are an *individual performing Provider*, answer (a), (b), and (c) for yourself. If you are a *business or group practice*, answer (a), (b), and (c) for all persons listed in (1) or (2) above.

Have you or any member of the business or group practice been:

(a) Excluded from or received a notice of exclusion from participation in any federal or state health care program?

No Yes. If *yes*, please explain: _____

(b) Convicted of any crime related to any public assistance, Medicare, Medicaid or Title XX program?

No Yes. If *yes*, please explain (include the crime, date, and jurisdiction of conviction):

(c) Disciplined in any way by a professional licensing board in any state?

Definition: "Disciplined" includes, but is not limited to, having a license revoked, suspended, or continued under conditions which are not part of the original license (e.g., licensee may continue to practice but may not prescribe controlled substances; licensee may continue to practice but must pay restitution or other costs, attend continuing education classes, etc.).

"Disciplined" also includes revocation or surrender of a license or agreement to not have a license renewed, in exchange for a Board's agreement not to seek revocation, suspension, or conditional continuance of a license previously granted.

"Discipline," as defined in this section, is to be broadly construed.

No Yes. If *yes*, please explain: _____

PROVIDER: By signing this Provider Certification you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate.

Signature of Provider or Authorized Business Representative

Date

Title of Business Representative

