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ARCHIVES DIVISION

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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
10/19/2023 11:39 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Update EPSDT language; move division 130 rule to 151 and update rules for EPSDT Program.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2023 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

Bring EPSDT rules into compliance with federal requirements. Update EPSDT definitions, Medical Necessity and Medical Appropriateness for federal requirements. Move EPSDT to it's own division and update program rules.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Medicaid.gov

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

A comprehensive EPSDT benefit is intended to positively impact equitable access to care for children and youth enrolled in the Oregon Health Plan by establishing and setting accountability for robust standards for health care coverage. We know that over 500,000 children and youth under 21 are enrolled in the Oregon Health Plan, and 38 percent of non-elderly OHP members are people of color. The EPSDT program is a critical avenue for OHA to identify and address disparities in access and quality of care that are based on current and historical racism.

FISCAL AND ECONOMIC IMPACT:

The fiscal impact of EPSDT requirements for expanded coverage for OHP members under age 21 is primarily due to payment for treatments and services that historically were not covered for this population. Effective January 1, 2023, services below the funding on the Prioritized List of Health Services must be covered for this population when medically necessary and medically appropriate. There will be some administrative costs to Coordinated Care Organizations, the Oregon Health Authority and some OHP provider practices due to system and process changes to align with EPSDT requirements. The estimated total cost of EPSDT implementation for the 2023-2025 biennium is \$9,834,922. This includes \$3,496,566 in General Fund and \$6,338,356 in Federal Funds.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1. This is included in the above fiscal and economic impact above.

2.

(a) None

(b) None

(c) None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-120-0000, 410-120-1200, 410-130-0245, 410-151-0000, 410-151-0001, 410-151-0002, 410-151-0003, 410-151-0004, 410-151-0005, 410-151-0006, 410-151-0007, 410-151-0008

AMEND: 410-120-0000

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

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), Health Systems Division (Division) 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 410-141-3500 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 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 medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.¶¶

(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a CCO member, refer to OAR 410-141-3500.¶¶

(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶¶

(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶¶

(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶¶

(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶¶

(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶¶

- (8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
- (9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the OHP 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.¶
- (10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
- (11) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
- (12) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
- (13) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)".¶
- (14) "All-Inclusive Rate" or "Bundled 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.¶
- (15) "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 individuals (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), and federally recognized American Indian tribes).¶
- (16) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with an MCE, 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.¶
- (17) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
- (18) "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).¶
- (19) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
- (20) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and 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.¶
- (21) "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).¶
- (22) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
- (23) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
- (24) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
- (25) "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.¶
- (26) "Atypical Provider" means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
- (27) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
- (28) "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.¶

- (29) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
- (30) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
- (31) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
- (32) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
- (33) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
- (34) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
- (35) "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.¶
- (36) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
- (37) "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 OAR 410-120-1350 Buying Up.)¶
- (38) "By Report (BR)" means services designated, as BR requires 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.¶
- (39) "Case Management Services" means 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, substance use disorder 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 that may include referrals to Allied Agencies.¶
- (40) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶
- (41) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.¶
- (42) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
- (43) "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.¶
- (44) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
- (45) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
- (46) "Citizenship Waived Medical (CWM)" means Medicaid coverage for emergency medical needs (OAR 410-134-0003(1)) for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do not meet citizenship and/or non-citizen status requirements (OAR 410-200-0240).¶
- (47) "Claimant" means an individual who has requested a hearing.¶
- (48) "Client" means an individual found eligible to receive OHP health services.¶
- (49) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
- (50) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
- (51) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
- (52) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
- (53) "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.¶
- (54) "Community Health Worker" means an individual who:¶

- (a) Has expertise or experience in public health;¶
 - (b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
 - (c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
 - (d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
 - (e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
 - (f) Provides health education and information that is culturally appropriate to the individuals being served;¶
 - (g) Assists community residents in receiving the care they need;¶
 - (h) May give peer counseling and guidance on health behaviors; and¶
 - (i) May provide direct services such as first aid or blood pressure screening.¶
- (55) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
- (56) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
- (57) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
- (a) A client or member or their representative;¶
 - (b) A member of an MCE after resolution of the MCE's appeal process;¶
 - (c) An MCE member's provider; or¶
 - (d) An MCE.¶
- (58) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
- (59) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
- (60) "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.¶
- (61) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶
- (62) "Co-Payments" means 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 OAR 410-120-1230 Client Copayment.)¶
- (63) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
- (64) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules ~~and~~. Covered services include: ¶
- ~~(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature.~~
 - ~~Covered services include services that are;~~ and ¶
 - ~~(a)~~ Ancillary services (OAR 410-120-0000(22)); and¶
 - ~~(b)~~ Diagnostic services necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition; and¶
 - ~~(c)~~ Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k; and¶
 - ~~(d)~~ Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver). (EPSDT) as described in chapter 410 Division 151. ¶
- (65) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
- (66) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
- (67) "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.¶

(68) "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.¶

(69) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning ~~his or her~~ their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶

(70) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶

(71) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶

(72) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶

(73) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶

(74) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶

(75) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶

(76) "Dental Hygienist with an Expanded Practice Permit" means an individual 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.¶

(77) "Dentally Appropriate" ¶

(a) means health dental services, items, or dental supplies that are:¶

(aA) Recommended by a licensed health provider practicing within the scope of their license; and¶

(bB) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶

(cC) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶

(dD) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement;¶

(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services;¶

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.¶

(78) "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.¶

(79) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶

(80) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶

(81) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶

(82) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶

(83) "Division (Division)" means the Health Systems 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.¶

(84) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means 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.¶

(85) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (aka, Medichex)" means the Title XIX program of EPSDT services for eligible clients under program requiring specific cover-age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them for children and young adults, as defined in chapter 410 Division 151. ¶

(86) "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 OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal. ¶

(87) "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. ¶

(88) "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. ¶

(89) "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. ¶

(90) "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 person, the health of the person or their 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. ¶

(91) "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. ¶

(92) "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. ¶

(93) "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 evaluation [sic] 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)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings. ¶

(94) "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. ¶

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

(96) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that: ¶

(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program; ¶

(b) Is qualified to participate in 340B discount purchasing as an HTC; ¶

(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has a identification number that is listed in the HTC directory on the CDC website; ¶

(d) Is recognized by the Federal Regional Hemophilia Network that includes the state of Oregon; and ¶

(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶

(97) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that 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.¶

(98) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). 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.¶

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

(100) "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 Authority for full medical assistance coverage.¶

(101) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶

(102) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶

(103) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶

(104) "Health Care Professionals" means 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.¶

(105) "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, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.¶

(106) "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.¶

(107) "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.¶

(108) "Health Maintenance Organization (HMO)" means a public or private health care organization that 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.¶

(109) "Health Plan New/non-categorical 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.¶

(110) "Hearing Aid Dealer" means an individual 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.¶

(111) "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.¶

(112) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that 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.¶

(113) "Home Health Services" means 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.¶

(114) "Home Intravenous Services" means 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.¶

(115) "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.¶

(116) "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 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 is currently licensed by the Oregon Health Authority, Public Health Division.¶

(117) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall 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.¶

(118) "Hospital-Based Professional Services" means 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.¶

(119) "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 or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶

(120) "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.¶

(121) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶

(122) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶

(123) "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.¶

(124) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.¶

(125) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶

(126) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶

(127) "Inpatient Hospital Services" means 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.)¶

(128) "Institutional Level of Income Standards (ILIS)" means 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 Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶

(129) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.¶

(130) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶

(131) "Joint fair hearing request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity

described in 42 CFR 435.1200.¶

(132) "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 and 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).¶

(133) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their 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.¶

(134) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶

(135) "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.¶

(136) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶

(137) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶

(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;¶

(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶

(138) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶

(139) "Managed Care Organization (MCO)" means a 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), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶

(140) "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 that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶

(141) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶

(142) "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.¶

(143) "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.¶

(144) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶

(145) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶

(146) "Medical Transportation" means transportation to or from covered medical services.¶

(147) "Medically Appropriate:" ¶¶

(a) Means health services, items, or medical supplies that are:¶

(aA) Recommended by a licensed health provider practicing within the scope of their license; and¶

(bB) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and

(cC) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and

(dD) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;

(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

(148) "Medically Necessary" means:

(a) Health services and items that are required by a client or member to address one or more of the following:

(aA) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could results in health impairments or a disability; or

(bB) The ability for a client's or member's ability to achieve age-appropriate growth and development; or

(cC) The ability for a client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(dD) The ~~opportunity for a client's or member receiving Long Term Services & Supports (LTSS) as defined in these rules's~~ ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;

~~(e, when they are receiving Long Term Services or Supports (as defined in these rules).~~

(b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

(149) "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 that 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. It 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.

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

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

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

(153) "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.

(154) "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.

(155) "National Provider Identification (NPI)" means federally administered 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 and Medicaid covered entities are required to apply for an NPI.

(156) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(157) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.

- (158) "Non-covered Services" means 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) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶¶
 - (c) OAR 410-141-3820 OHP Benefit Package of Covered Services;¶¶
 - (d) OAR 410-141-0520 Prioritized List of Health Services;¶¶
 - (e) OAR 410-134-0003 CWM Benefit Plans and State-Funded Supplemental Wraparound Services; and¶¶
 - (f) Any other applicable Division administrative rules.¶¶
- (159) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.¶¶
- (160) "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).¶¶
- (161) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶¶
- (162) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶¶
- (163) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶¶
- (164) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶¶
- (165) "Nursing Services" means 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.¶¶
- (166) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶¶
- (167) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶¶
- (168) "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, the 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.¶¶
- (169) "Ombudsman Services" means 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.¶¶
- (170) "Oregon Health ID" means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.¶¶
- (171) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that 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.¶¶
- (172) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶¶
- (173) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶¶
- (174) "Oregon Health Authority (Authority)" 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 Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶¶
- (175) "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.¶¶
- (176) "Out-of-State Providers" means 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.¶¶
- (177) "Outpatient Hospital Services" means 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 chapter 410, division 125.¶

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

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

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

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

(182) "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.¶

(183) "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.¶

(184) "Peer Support Specialist" including Family Support Specialist and Youth Support Specialist has the meaning given that term in OAR 410-180-0305.¶

(185) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶

(186) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and will assist the patient in achieving the goals.¶

(187) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.¶

(188) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶

(189) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶

(190) "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 individual.¶

(191) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶

(192) "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 may not include radiology or electrosurgery.¶

(193) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶

(194) "Physician Assistant" means an individual 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.¶

(195) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶

(196) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶

(197) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶

(198) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶

(199) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶

(200) "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), Mental Health Organization (MHO), or Physician Care Organization (PCO)¶

(201) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating

initial and primary dental care within their scope of practice for their members.¶

(202) "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. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶

(203) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶

(204) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶

(205) "Private Duty Nursing Services" means 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.¶

(206) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶

(207) "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) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶

(208) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶

(209) "Public Health Clinic" means a clinic operated by a county government.¶

(210) "Public Rates" means 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.¶

(211) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶

(212) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶

(213) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶

(214) "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.¶

(215) "Radiological Services" means 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.¶

(216) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶

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

(218) "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.¶

(219) "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.¶

(220) "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.¶

(221) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶

(222) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶

(223) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶

(224) "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.¶

(225) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶

(226) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶

(227) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.¶

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

(229) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶

(230) "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.¶

(231) "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.¶

(232) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶

(233) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶

(234) "Speech-Language Pathology Services" means 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.¶

(235) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶

(236) "Subparts (of a Provider Organization)" means 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 and could be components of an organization or separate physical locations of an organization.¶

(237) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).¶

(238) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶

(239) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶

(240) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶

(241) "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 shall be reactivated automatically after the suspension period has elapsed.¶

(242) "Targeted Case Management (TCM)" means activities that 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.¶

(243) "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.¶

(244) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶

(245) "Transportation" means medical transportation.¶

(246) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶

(247) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶

(248) "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.¶

(249) "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.¶

(250) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶

(251) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶

(252) "Urgent Care Services" means 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.¶

(253) "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 percent 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.¶

(254) "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.¶

(255) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶

(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).¶

(256) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:¶

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶

(257) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶

(258) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.

Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-120-1200

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-120-1200

Excluded Services and Limitations ¶

(1) Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to ~~either:~~¶

~~(a) The Health Evidence Review Commission (HERC) Prioritized List of Health Services as referenced in OAR 410-141-3830 and the individual program chapter 410 OARs; or~~¶

~~(b) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in chapter 410 Division 151.~~¶

~~(2) If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.~~¶

~~(23) The Health Systems Division shall make no payment for any expense incurred for any of the following services or items that are:~~¶

~~(a) Not expected to significantly improve the basic health status of the client as determined by Health Systems Division (HSD) staff or its contracted entities; for example, the HSD's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);~~¶

~~(b) Determined not medically or dentally appropriate by HSD Division staff or authorized representatives, including the Health Systems Division's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;~~¶

~~(c) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within their scope of practice or licensure;~~¶

~~(d) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes;~~¶

~~(e) Provided by friends or relatives of eligible clients or members of ~~this or~~ heir household, except when the friend, relative or household member:~~¶

~~(A) Is a health professional acting in a professional capacity; or~~¶

~~(B) Is directly employed by the client under the Oregon Department of Human Services (Department) Aging and People with Disabilities division (APD) Home and Community Based Services or the APD administrative rules, OAR 411-034-0000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or~~¶

~~(C) Is directly employed by the client under the Department Child Welfare administrative rules in Chapter 413, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of 18) must not be legally responsible for the client in order to be a provider of personal care services;~~¶

~~(f) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Health Systems Division's administrative rules (i.e., inpatient hospitalizations);~~¶

~~(g) Needed for purchase, repair, or replacement of materials or equipment caused by adverse actions of adult clients age 21 and over to personally owned goods or equipment or to items or equipment that the Health Systems Division rented or purchased;~~¶

~~(h) Related to a non-covered service, some exceptions are identified in the individual provider rules. If the Health Systems Division determines the provision of a service related to a non-covered service is cost effective, the related medical service may, at the discretion of HSD the Division and with HSD Division prior authorization (PA), be covered;~~¶

~~(i) Considered experimental or investigational, that deviates from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;~~¶

~~(j) Identified in the appropriate program rules including the Health Systems Division's Hospital Services program administrative rules, Revenue Codes Section, as non-covered services;~~¶

~~(k) Requested by or for a client whom the Health Systems Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;~~¶

- (ll) For copying or preparing records or documents, except those Administrative Medical Reports requested by the branch offices or the ~~Health Systems~~ Division for casework planning or eligibility determinations;¶
- (m) Whose primary intent is to improve appearances, exceptions subject to the HERC coverage and guidelines;¶
- (n) Similar or identical to services or items that ~~sh~~will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client ~~sh~~will be essentially the same;¶
- (o) For the purpose of establishing or reestablishing fertility or pregnancy;¶
- (p) Items or services that are for the convenience of the client and are not medically or dentally appropriate;¶
- (q) The collection, processing, and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;¶
- (r) Educational or training classes that are not intended to improve a medical condition;¶
- (s) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;¶
- (t) Post-mortem exams or burial costs;¶
- (u) Radial keratotomies;¶
- (v) Recreational therapy;¶
- (w) Telephone calls except for:¶
 - (A) Tobacco cessation counseling as described in OAR 410-130-0190;¶
 - (B) Maternity case management as described in OAR 410-130-0595;¶
 - (C) Telemedicine as described in OAR 410-120-1990; and¶
 - (D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health division.¶
- (x) Services that have no standard code set as established according to 45 CFR 162.1000 to 162.1011, unless the ~~Health Systems~~ Division has assigned a procedure code to a service authorized in rule;¶
- (y) Whole blood (Whole blood is available at no cost from the Red Cross). The processing, storage, and costs of administering whole blood are covered;¶
- (z) Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;¶
 - (aa) Missed appointments, an appointment that the client fails to keep. Refer to OAR 410-120-1280;¶
 - (bb) Transportation to meet a client's personal choice of a provider;¶
 - (cc) Alcoholics Anonymous (AA) and other self-help programs;¶
 - (dd) Medicare Part D covered prescription drugs or classes of drugs and any cost sharing for those drugs for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package;¶
 - (ee) Services provided outside of the United States. Refer to OAR 410-120-1180.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065, 414.025

REPEAL: 410-130-0245

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

~~410-130-0245~~

~~Early and Periodic Screening, Diagnostic and Treatment Program~~

~~(1) The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly called Medichex, offers "well-child" medical exams with referral for medically appropriate comprehensive diagnosis and treatment for all children (birth through age 20) covered by the Oregon Health Plan (OHP) Plus benefit package.~~

~~(2) Screening Exams:~~

~~(a) Physicians (MD or DO), nurse practitioners, licensed physician assistants and other licensed health professionals may provide EPSDT services. Screening services are based on the definition of "Preventive Services" in Oregon Health Plan OAR 410-141-0000, Definitions;~~

~~(b) Periodic EPSDT screening exams must include:~~

~~(A) A comprehensive health and developmental history including assessment of both physical and mental health development;~~

~~(B) Assessment of nutritional status;~~

~~(C) Comprehensive unclothed physical exam including inspection of teeth and gums;~~

~~(D) Appropriate immunizations;~~

~~(E) Lead testing as required by OAR 410-130-0246;~~

~~(F) Other appropriate laboratory tests (such as anemia test, sickle cell test, and others) based on age and client risk;~~

~~(G) Health education including anticipatory guidance;~~

~~(H) Appropriate hearing and vision screening.~~

~~(c) The provider may bill for both lab and non-lab services using the appropriate Current Procedural Terminology (CPT) and Health care Common Procedure Coding System (HCPCS) codes. Immunizations must be billed according to the guidelines listed in OAR 410-130-0255;~~

~~(d) Inter-periodic EPSDT screening exams are any medically appropriate encounters with a physician (MD or DO), nurse practitioner, licensed physician assistant, or other licensed health professional within their scope of practice.~~

~~(3) Referrals:~~

~~(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to an appropriate provider for further diagnosis and/or treatment;~~

~~(b) The screening provider shall explain the need for the referral to the client, client's parent, or guardian;~~

~~(c) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate referral provider and making an appointment should be offered;~~

~~(d) The child's CCO or the FFS program will also make available care coordination as needed.~~

~~Statutory/Other Authority: ORS 413.042~~

~~Statutes/Other Implemented: ORS 414.025, 414.065, 414.150~~

ADOPT: 410-151-0000

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0000

Early and Periodic Screening, Diagnostic and Treatment Program

(1) The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventive health care services to EPSDT Beneficiaries in accordance with 42 CFR § 441 Subpart B. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional, and mental and behavioral health conditions. Coverage for EPSDT Beneficiaries includes all services coverable under the Oregon Health Plan (OHP), when EPSDT Medically Necessary and EPSDT Medically Appropriate for the EPSDT Beneficiary. ¶

(2) The EPSDT rules in this division relating specifically to the provision of OHP services for EPSDT Beneficiaries take precedence over any and all general rules relating to the provision of OHP services to the general OHP population set forth in Oregon Administrative Rules Chapters 410 and 309.¶

(3) Physicians or other practitioners of the healing arts as defined in OAR 410-120-0000 within the scope of their practice under State law may provide OHP services to EPSDT Beneficiaries.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0001

Definitions

The definitions in this rule apply to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program only. ¶

(1) "EPSDT Dentally Appropriate" ¶

(a) Means dental services, items, or dental supplies that are: ¶

(A) Recommended by a licensed health provider practicing within the scope of their license; and ¶

(B) Safe, effective and appropriate for an EPSDT Beneficiary based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and ¶

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities; and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item or dental supply; and ¶

(D) The most cost-effective level or type of health services, items, or supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary. ¶

(b) All covered services must be EPSDT Dentally Appropriate for the EPSDT Beneficiary but not all EPSDT Dentally Appropriate services are covered services. ¶

(2) "EPSDT Beneficiary" means an individual under the age of 21 who is covered by the Oregon Health Plan (OHP). ¶

(3) "EPSDT Medically Appropriate:" ¶

(a) Means health services, items, or medical supplies that are: ¶

(A) Recommended by a licensed health provider practicing within the scope of their license; and ¶

(B) Safe, effective, and appropriate for the EPSDT Beneficiary and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and ¶

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or medical supply; and ¶

(D) The most cost-effective level or type of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary. ¶

(b) All covered services must be EPSDT Medically Appropriate for the EPSDT Beneficiary, but not all EPSDT Medically Appropriate services are covered services. ¶

(4) "EPSDT Medically Necessary:" ¶

(a) Means health services, items and medical supplies that are required to address one or more of the following for an EPSDT Beneficiary: ¶

(A) The prevention, diagnosis, treatment or amelioration of an EPSDT Beneficiary's disease, condition, or disorder that results in health impairments or a disability; ¶

(B) The ability for an EPSDT Beneficiary to achieve age-appropriate growth and development. Services that may be EPSDT Medically Necessary to achieve age-appropriate growth and development include but may not be limited to services that are reasonably calculated to improve the EPSDT Beneficiary's ability to participate in work or school, or the prevention, diagnosis, detection, treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability, regardless of whether they are included on the Prioritized List of Health Services (defined in OAR 410-120-0000) or are below the funding line on the Prioritized List of Health Services; ¶

(C) The ability for an EPSDT Beneficiary to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or ¶

(D) The opportunity for an EPSDT Beneficiary receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, and to live and work in the setting of their choice. ¶

(b) An EPSDT Medically Necessary service must also be EPSDT Medically Appropriate. All covered services must be EPSDT Medically Necessary for the EPSDT Beneficiary.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0002

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0002

Coverage Requirements

(1) The coverage requirements for services to EPSDT Beneficiaries set forth in this Rule supersede any other coverage standards or requirements set forth in any other Medical Assistance rules that are applicable to non-EPSDT Beneficiaries, regardless of whether the other standards or requirements conflict or are otherwise inconsistent with the EPSDT coverage requirements in this Rule. ¶

(2) The Oregon Health Authority (the Authority) and Managed Care Entities (MCEs) must cover services that are EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for EPSDT Beneficiaries, even if: ¶

(a) The services are not included on the Prioritized List of Health Services (defined in OAR 410-120-0000); or ¶

(b) The service is below the funding line on the Prioritized List of Health Services. ¶

(3) The Authority and MCEs may not deny coverage of services for EPSDT Beneficiaries without a case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPSDT Dental Appropriateness). It is allowable for services to be denied for EPSDT Beneficiaries after a case-by-case review in which it is determined by the Authority or the MCE that the service is not EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for that specific EPSDT Beneficiary. Specific circumstances in which the Authority and MCEs may deny coverage of services for an EPSDT Beneficiary are outlined in a guidance document, effective January 1, 2023, available at <https://www.oregon.gov/oha/HSD/OHP/Tools/EPSDT-Guidance.pdf>. ¶

(4) The Authority and MCEs must cover Durable Medical Equipment for EPSDT Beneficiaries in accordance with sections (1) through (3) of this rule and OAR 410-122-0010 through OAR 410-122-0720. ¶

(5) Providers shall not refuse to render or refer for EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) care. Coverage decisions must be made by the Authority or the MCE in accordance with the requirements in sections (1) through (4) of this rule and any denial of coverage must be provided in writing by the Authority or the MCE in accordance with the requirements in OAR 410-151-0007.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0003

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0003

Utilization Management Requirements

(1) The Oregon Health Authority (Authority) and Managed Care Entities (MCEs) do not have the right to pre-establish limits or caps on the amount of services or number of visits covered for EPSDT Beneficiaries. Instead, coverage decisions must be made in accordance with OAR 410-151-0002. However, it is acceptable to establish limits (for example, 10 physical therapy visits) subject to prior authorization for coverage of additional services. ¶

(2) The Authority and MCEs do not have the right to require prior authorization for any EPSDT screening services. ¶

(3) The Authority and MCEs shall promptly complete prior authorization procedures in accordance with OAR 410-141-3835 and OAR 410-130-1200 and the individual program chapter 410 and 309 OARs as applicable. ¶

(4) The Authority and MCEs shall ensure prompt delivery of EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) services to EPSDT Beneficiaries.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0004

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0004

Screening Exams

(1) Periodic EPSDT screening exams must be provided in accordance with the Bright Futures Periodicity Schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf) and must include:

(a) A comprehensive health and developmental history including assessment of both behavioral health and physical health development;

(b) Assessment of nutritional status;

(c) Comprehensive unclothed physical exam including inspection of teeth and gums;

(d) Appropriate immunizations;

(e) Lead testing as required by OAR 410-130-0246;

(f) Other appropriate laboratory tests (including but not limited to anemia test and sickle cell test) based on age and EPSDT Beneficiary risk;

(g) Health education including anticipatory guidance; and

(h) Appropriate hearing and vision screening.

(2) EPSDT providers may bill for both lab and non-lab services using the appropriate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. Immunizations must be billed according to the guidelines listed in OAR 410-130-0255;

(3) Inter-periodic EPSDT screening exams are any EPSDT Medically Necessary and EPSDT Medically Appropriate encounters with a physician or other licensed practitioner of the healing arts within their scope of practice under State law. Inter-periodic EPSDT exams may occur at any time and may be warranted when the EPSDT Beneficiary has been ill or has experienced a change in health or development.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0005

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0005

Referrals

- (1) If, during the EPSDT screening process, a medical, behavioral health, nutritional, or dental condition is discovered, the EPSDT Beneficiary shall be referred to an appropriate provider for further diagnosis and, when EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate), receive treatment.¶
 - (2) The screening provider shall explain the need for the referral to the EPSDT Beneficiary, and, when applicable, the EPSDT Beneficiary's parent or guardian.¶
 - (3) If the EPSDT Beneficiary, EPSDT Beneficiary's parent or guardian agrees to the referral, the referring provider shall offer assistance in finding an appropriate referral provider and making an appointment.¶
 - (4) The EPSDT Beneficiary's MCE or the Authority shall also make available care coordination as needed.
- Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0006

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0006

Transportation and Scheduling Assistance

In accordance with the responsibilities in OAR 410-136-3000, the Authority or the MCE must offer and provide, when requested by the EPSDT Beneficiary or their parent or guardian: ¶

(1) Transportation assistance to covered services; ¶

(2) Scheduling assistance for appointments for covered services.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0007

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0007

Notice and Hearing Requirements

If the Authority or an MCE takes action to deny, suspend, reduce or terminate services for an EPSDT Beneficiary, it must provide the EPSDT Beneficiary, and, as applicable, the EPSDT Beneficiary's parent or guardian, with a written notice that complies with the requirements in OAR 410-141-3885 and OAR 410-120-1865, which require, without limitation: ¶

(1) A statement of the intended action and effective date; ¶

(2) The specific reasons and legal support for the action; ¶

(3) An explanation of the EPSDT Beneficiary's appeal and hearing rights; ¶

(4) The EPSDT Beneficiary's rights to representation.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

ADOPT: 410-151-0008

RULE SUMMARY: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventative health care services to BEPSDT Beneficiaries. EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional and mental and behavioral health conditions for children and youth ages 0-21.

CHANGES TO RULE:

410-151-0008

EPSDT Beneficiary Communication Requirements

The Authority and MCEs must notify EPSDT Beneficiaries and, as applicable, the EPSDT Beneficiary's parent or guardian, about services covered under EPSDT and how to access them, in accordance with a guidance document which became effective January 1, 2023 and is available at <https://www.oregon.gov/oha/HSD/OHP/Tools/EPSDT-Guidance.pdf>. The notice must comply with the criteria for written materials set forth in OAR 410-141-3585 and be sent to EPSDT Beneficiaries and, as applicable, the EPSDT Beneficiary's parent or guardian in accordance with the following timelines:¶
(1) Within 60 days of an EPSDT Beneficiary enrolling in Oregon Health Plan (OHP) coverage; ¶
(2) Immediately following birth for newborn infants; and¶
(3) Annually for any EPSDT Beneficiary who has not undergone an EPSDT screening or used other OHP services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.150