OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
11/30/2023 11:02 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 84-2023

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

FILING CAPTION: Add Definitions, Remove Outdated Language, Align with CMS, And Improve Clarity

EFFECTIVE DATE: 12/01/2023

AGENCY APPROVED DATE: 11/30/2023

CONTACT: nita kumar
503-847-1357
hsd.rules@oha.oregon.gov

500 Summer St NE
salem,OR 97301

Filed By:
Nita Kumar
Rules Coordinator

RULES:
410-120-0000, 410-120-1180, 410-120-1200, 410-120-1260, 410-120-1340, 410-120-1360, 410-120-1400

AMEND: 410-120-0000

REPEAL: Temporary 410-120-0000 from DMAP 55-2023

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Updating definitions to include definitions we should have already had, and amend ones that could be more clear.

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 Coordinated Care Organization (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 O~~HP~~regon Health Plan (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, ~~a~~Area ~~a~~Agencies on ~~a~~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~~ Managed Care Entity (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) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not

include voice messages, facsimile, electronic mail or text messages.¶
(27) "Atypical Provider" means an entity able to enroll as a ~~b~~Billing ~~p~~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.¶
(2~~7~~8) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(2~~8~~9) "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~~30) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.¶
(31) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(3~~0~~2) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(3~~1~~3) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(3~~2~~4) "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.¶
(3~~3~~5) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(3~~4~~6) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
(3~~5~~7) "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.¶
(3~~6~~8) "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.¶
(3~~7~~9) "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~~40) "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 ~~wi~~shall facilitate evaluation.¶
(~~39~~41) "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.¶
(4~~0~~2) "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 a~~n 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.~~ community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon. OAR 950-060-0010(19)¶
(4~~2~~3) "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.¶
(4~~3~~4) "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.¶
(4~~4~~5) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(4~~5~~6) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(4~~6~~7) "Citizenship Waived Medical (CWM)" means ~~Medicaid coverage for emergency medical needs (OAR 410-~~

~~134-0003(1)) for individuals who otherwise~~Emergency-Only Health Benefits for individuals who prior to June 30, 2023, meet the financial and non-financial eligibility requirements for an HSD Medical Program, ex~~pec~~cept they d~~o~~id not meet citizenship ~~and/~~or non-citizen status requirements (OAR 410-200-0240).¶
(4~~7~~8) "Claimant" means an individual who has requested a hearing.¶
(4~~8~~9) "Client" means an individual found eligible to receive OHP health services.¶
(4~~9~~50) "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.¶
(5~~0~~1) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(5~~1~~2) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(5~~2~~3) "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.¶
(5~~3~~4) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal ~~i~~illness, including the combination of medical and related services designed to make it possible for an individual with terminal ~~i~~illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(5~~4~~5) "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~~require;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(5~~5~~6) "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 (HERC), 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 the Prioritized List of Health Services above the funding line

set by the legislature. Covered services include services that are:¶
(a) Ancillary ~~s~~Services ~~(~~OAR 410-120-0000 (22)~~)~~;¶
(b) Diagnostic ~~s~~Services ~~necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition~~OAR 410-120-0000 (82);¶
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k;¶
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnos~~is~~tic and Treatment ~~as specified in the Oregon Health Plan 1115 Demonstration Project (waiver~~(EPSDT).¶
(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) Credible Allegation of Fraud means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.¶
(68) "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.¶
(6~~8~~9) "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.¶
(70) "Deactivation" means an action prohibiting a provider's participation where the Authority assigned provider number is terminated as the result of inactivity, as evidenced by failure to submit claims for eighteen (18) months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier.(69) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning ~~his or he~~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.¶
(7~~0~~1) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(7~~1~~2) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶
(7~~2~~3) "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.¶
(7~~3~~4) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(7~~4~~5) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶
(7~~5~~6) "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.¶
(7~~6~~7) "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.¶
(7~~7~~8) "Dentally Appropriate"¶
(a) means health services, items, or dental supplies that are:¶
(~~a~~A) Recommended by a licensed health provider practicing within the scope of their license; and¶
(~~b~~B) 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¶
(~~c~~C) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶
(~~d~~D) 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~~;~~.(X¶
(~~e~~b) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.¶

(~~78~~c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.¶
(79) "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~~80) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(8~~0~~1) "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.¶
(8~~1~~2) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(8~~2~~3) "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.¶
(8~~3~~4) Dietitian: An individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, Chapter 834, Division 60 (OAR 834-060-0000).¶
(85) "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.¶
(8~~4~~6) "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.¶
(8~~5~~7) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.¶
(8~~6~~8) "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.¶
(8~~7~~9) "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~~90) "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~~91) "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.¶
(9~~0~~2) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, 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~~the pregnant person, the health of the perso~~m~~n or their ~~unborn child~~pregnancy) in serious jeopardy, serious impairment to bodily functions~~,~~ or serious dysfunction of any bodily organ or part. An emergency medical condition is ~~determined~~not based on the final diagnosis, but is 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.¶
(9~~1~~3) "Emergency-Only Health Benefits" means Emergency Medical Conditions defined in OAR 410-134-0003(2)(a)(C)(i)(I-VIII) and OAR 410-134-0003(2)(b)(C)(ii) eligible for Medicaid match. (42 CFR 440.255)¶
(94) "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.¶
(9~~2~~5) "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.¶

(9~~3~~6) "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~~considers the quality of evidence and the confidence that may be placed in findings.¶
(9~~4~~7) "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~~may result, or has resulted, in an overpayment.¶
(9~~5~~8) "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.¶
(9~~6~~9) "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 an 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 ~~s~~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~~100) "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~~101) "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~~102) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception ~~could~~may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶
(10~~0~~3) "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.¶
(10~~1~~4) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(10~~2~~5) "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.¶
(10~~3~~6) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(10~~4~~7) "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.¶
(10~~5~~8) "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 ~~C~~current Dental Terminology (~~C~~DT) codes for the reporting of dental care services and procedures.¶
(10~~6~~9) "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.¶
(1107) "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.¶
(10811) "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.¶
(10912) "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.¶
(1103) "Healthier Oregon" means Emergency-Only Health Benefits defined OAR 410-120-0000(91) and State Funded Supplemental Health Benefits OAR 410-120-0000(238) provide benefits equal to OHP for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD or OSIPM Medical Program, except that they do not meet citizenship status requirements (OAR 410-200-0240 and 461-101-0010).¶
(114) "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.¶
(1145) "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.¶
(1126) "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.¶
(1137) "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.¶
(1148) "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.¶
(1159) "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.¶
(11620) "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.¶
(1217) "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.¶
(11822) "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 (divisionDMAP 42) report for the Division.¶
(11923) "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).¶
(1204) "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.¶
(1215) "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).¶
(12~~2~~6) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(12~~3~~7) "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.¶
(12~~4~~8) "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 may also ~~may~~ include the Service.¶
(12~~5~~9) "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).¶
(1~~26~~30) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶
(1~~27~~31) "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.)¶
(13~~2~~8) "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.¶
(1~~29~~33) "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.¶
(13~~0~~4) "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.¶
(13~~1~~5) "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.¶
(13~~2~~6) "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).¶
(13~~3~~7) "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.¶
(13~~4~~8) "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.¶
(13~~5~~9) "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.¶
(1~~36~~40) "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.¶
(1~~37~~41) "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).¶
(13842) "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.¶
(1439) "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).¶
(1404) "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the provider, whether the provider is an individual, institution, organization or agency. ¶
(145) "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.¶
(1416) "Meaningful access" means client or member-centered access reflecting the following statute and standards:¶
(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), providers' telemedicine or telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92;¶
(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and¶
(c) As applicable to the client or member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;¶
(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.¶
(147) "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.¶
(1428) "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.¶
(1439) "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.¶
(14450) "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).¶
(1451) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(14652) "Medical Transportation" means transportation to or from covered medical services.¶
(14753) "Medically Appropriate" means health services, items, or medical supplies that are:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) 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;¶
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;¶
(d) 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.¶
(1548) "Medically Necessary" means health services and items that are required by a client or member to address

one or more of the following:¶
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;¶
(b) The ability for a client or member to achieve age-appropriate growth and development;¶
(c) The ability for a client or member 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 a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules 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) 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.¶
(14955) "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.¶
(1506) "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.¶
(157) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(1528) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
(1539) "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.¶
(15460) "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 wishall display less than 11 digits, but the number assumes leading zeroes.¶
(15561) "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.¶
(1562) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(15763) "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.¶
(164) "Non-Billing Provider" also referred to as non-payable, means a provider who is issued a provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(1658) "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~~e) Any other applicable Division administrative rules.¶
(15~~9~~66) "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.¶
(16~~0~~7) "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).¶
(16~~1~~8) "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.¶
(16~~2~~9) "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.¶
(16~~3~~70) "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.¶
(16~~4~~71) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(16~~5~~72) "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.¶
(16~~6~~73) "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.¶
(16~~7~~4) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(16~~8~~75) "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.¶
(17~~6~~9) "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.¶
(17~~0~~7) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.¶
(17~~1~~8) "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.¶
(17~~2~~9) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶
(17~~3~~80) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(17~~4~~81) "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.¶
(17~~5~~82) "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.¶
(17~~6~~83) "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.¶
(17~~7~~84) "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.¶
(17~~8~~5) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(17~~9~~86) "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.¶
(18~~0~~7) "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.¶
(188) Ownership interest' means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that:¶
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;¶
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;¶
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;¶
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;¶
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or¶
(f) Is a partner in a disclosing entity that is organized as a partnership.¶
(189) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.¶
(190) "Participating provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(191) "Payable Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims directly to the Authority for payment.¶
(192) "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.¶
(1893) "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.¶
(1894) "Peer Support Specialist" including Family S means an individual providing services to another individual who shares a similar life experience with the peer support Sspecialist and Youth S(addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support Sspecialist shas the meaning given that term in OAR 410-180-0305.ll be:¶
(a) A self-identified individual currently or formerly receiving addictions or mental health services;¶
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;¶
(c) A self-identified individual in recovery from problem gambling.¶
OAR 950-060-0010(13)(a-c)¶
(1895) "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.¶
(1896) "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 wishall assist the patient in achieving the goals.¶
(1897) "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 ofconsidering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(1898) "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.¶
(1899) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(19200) "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.¶
(19201) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(19202) "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.¶
(19203) "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.¶
(~~19~~204) "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.¶
(~~19~~205) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(~~19~~206) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶
(~~19~~207) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(~~19~~208) "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.¶
(~~19~~209) "Practitioner" 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.¶
(2~~0~~10) "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)¶
(2~~0~~11) "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.¶
(2~~0~~12) "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.¶
(2~~0~~13) "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.¶
(2~~0~~14) "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.¶
(2~~0~~15) "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.¶
(2~~0~~16) "Provider" means an individual, facility, institution, corporate entity, or other organization ~~that~~enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a ~~b~~Billing ~~p~~Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶
(2~~0~~17) "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.)¶
(2~~0~~18) "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.¶
(2~~0~~19) "Public Health Clinic" means a clinic operated by a county government.¶
(2~~1~~20) "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.¶
(2~~1~~21) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶
(2~~1~~22) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible

for Division coverage.¶
(2~~1~~2) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶
(2~~1~~2) "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.¶
(2~~1~~2) "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.¶
(2~~1~~2) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶
(2~~1~~2) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶
(2~~1~~2) "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.¶
(2~~1~~2) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested 20 physical therapy visits and the Division denies the individual's coverage of 20 visits, covering instead only 10 visits-this is considered a denial of a service and could be appealed.¶
(230) "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.¶
(2~~2~~031) "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.¶
(232~~1~~) "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.¶
(2~~2~~233) "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.¶
(2~~2~~34) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(2~~2~~435) "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.¶
(2~~2~~536) "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.¶
(2~~2~~637) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(2~~2~~738) "Sanction" means an action against providers taken by the Authority in cases of ~~fraud,~~ misuse~~,~~ or abuse of ~~Division requirements~~ Oregon HealthAuthority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.¶
(2~~2~~839) "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.¶
(2~~2~~940) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(2~~3~~041) "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.¶
(242) "Service location" means the location of a provider when services are rendered.¶
(243~~1~~) "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.¶

(2~~32~~44) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(2~~33~~45) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(2~~34~~6) "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.¶
(2~~35~~47) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(2~~36~~48) "State Funded Supplemental Health Benefits" means benefits defined in OAR 410-134-0003(2)(a)(C)(ii)(I-VII).¶
(249) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization ~~would~~may 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.¶
(2~~37~~50) "Subrogation" means right of the state to stand in place of the client in the collection of ~~t~~Third ~~p~~Party ~~r~~Resources (TPR).¶
(2~~38~~51) "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).¶
(2~~39~~52) "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.¶
(2~~40~~53) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(2~~54~~1) "Suspension" means a temporary sanction prohibiting a provider's participation in the medical assistance programs by ~~deactivation of~~suspending the provider's Authority-assigned ~~billing~~provider number for a specified period of time or one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or State Funds ~~wi~~shall be made for services provided ~~during the suspension. The number shall be reactivated automatically after the suspension period has elaps~~while the provider is suspended.¶
(2~~42~~55) "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.¶
(2~~43~~56) "Telecommunication technologies" means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.¶
(257) "Telehealth" includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.¶
(258) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare.¶
(259) "Termination" means a sanction prohibiting a provider's participation in the ~~Division~~Oregon Health Authority's programs by canceling the provider's Authority-assigned ~~billing~~provider number and ~~agreement~~provider agreement for one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or state funds ~~wi~~shall 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.¶
(2~~44~~60) "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.¶
(2~~45~~61) "Transportation" means medical transportation.¶
(2462) "Trauma informed approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where

there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.¶
(263) "Trauma Informed Services" means those services provided using a trauma informed approach.¶
(264) "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.¶
(2477265) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(2488266) "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.¶
(2499267) "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.¶
(2505068) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(2515169) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(2525270) "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.¶
(2535371) "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 ŧThird þParty ŕResources (TPR) are to be considered.¶
(2545472) "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.¶
(2555573) "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).¶
(2565674) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who ~~would~~may 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.¶
(2575) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(2758) "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: 410-120-1180

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Clarify Out of State Pharmacy Services

CHANGES TO RULE:

410-120-1180
Medical Assistance Benefits: Out-of-State Services ¶

(1) A provider located in a state other than Oregon whose services are rendered in that state shall be licensed and otherwise certified by the proper agencies in the state of residence as qualified to render the services. Certain cities within 75 miles of the Oregon border may be closer for Oregon residents than major cities in Oregon, and therefore, these areas are considered contiguous areas, and providers are treated as providing in-state services.¶
(2) Out-of-state providers must enroll with the Authority as described in OARs 943-120-0320 and 410-120-1260, Provider Enrollment. Out-of-state providers must provide services and bill in compliance with these rules and the OARs for the appropriate type of services provided.¶
(3) Payment rates for out-of-state providers are established in the individual provider rules through contracts or service agreements and in accordance with OAR chapter 943, division 120 and OAR 410-120-1340, Payment.¶
(4) For enrolled non-contiguous, out-of-state providers, the Division reimburses for covered services under any of the following conditions:¶
(a) For clients enrolled in an MCE:¶
(A) The service is authorized by an MCE, and payment to the out-of-state provider is the responsibility of the MCE;¶
(B) If a client has coverage through an MCE, the request for non-emergency services must be referred to the MCE. Payment for these services is the responsibility of the MCE;¶
(C) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-state provider is cost effective, as determined by the MCE.¶
(D) MCE must provide all Members with the option to utilize mail order pharmacy services. MCE may use an out-of-state mail order provider when necessary to meet the needs of the Member, as long as the pharmacy has signed a participating provider agreement or subcontract with the MCE, is licensed to operate in state they reside, and adheres to out-of-state services and other applicable Division rules.¶
(b) For clients not enrolled in an MCE:¶
(A) The service to a Division client is emergent as defined in 410-120-0000;¶
(B) A delay in the provision of services until the client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;¶
(C) The Division authorized payment for the service in advance of the provision of services or is otherwise authorized in accordance with payment authorization requirements in the individual provider rules or in the General Rules;¶
(D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage;¶
(E) The client is traveling and unable to use an in-state pharmacy;¶
(F) The pharmacy is out-of-state and mail order; the primary insurance TPL policy requires the use of the pharmacy;¶
(G) The pharmacy is out-of-state and mail order and provides one or more pharmaceutical products that are only available through a limited distribution network.¶
(5) The Authority may give prior authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled provider under the following conditions:¶
(a) The service is billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage; or¶
(b) The Division covers the service or item under the specific client's benefit package; and¶
(c) The service or item is not available in the State of Oregon, or provision of the service or item by an out-of-state provider is cost effective, as determined by the Division; and¶
(d) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician.¶
(6) Laboratory analysis of specimens sent to out-of-state independent or hospital-based laboratories is a covered service and does not require PA. The laboratory must meet the same certification requirements as Oregon laboratories and must bill in accordance with Division rules.¶
(7) ~~The Division makes no r~~Reimbursement ~~for~~and services ~~provided to a client~~ outside the territorial limits of the United ~~S~~states.:¶
(a) For purposes of this provision, the United States includes the District of Columbia, Puerto Rico, the Virgin

Islands, Guam, the Northern Mariana Islands, and American Samoa;¶
(b) The division may not provide any payments for items or services to any financial institution or entity located outside of the United States pursuant to 1902(a)(80) of the Social Security Act.¶
(A) This provision also prohibits payments to telemedicine providers and pharmacies located outside of the United States; ¶
(B) This does not preclude providers from providing covered items and/or services to Medicaid beneficiaries provided that reimbursement is made to a financial institution or entities located within the United States.-¶
(8) The Division shall reimburse within limits described in these General Rules and in individual provider rules all services provided by enrolled providers to children:-¶
(a) Who the Division has placed in foster care;-¶
(b) Who the Department has placed in a subsidized adoption outside the State of Oregon; or-¶
(c) Who are in the custody of the Department and traveling with the consent of the Department.-¶
(9) The Division does not require authorization of non-emergency services for the children covered by section (8) except as specified in the individual provider rules.-¶
(10) Payment rates for out-of-state providers are established in the individual provider rules through contracts or service agreements and in accordance with OAR 943-120-0350 and 410-120-1340, Payment.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025

AMEND: 410-120-1200

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Remove language for “significantly improve” in section (2)(a)

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 the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in Oregon Administrative Rule (OAR) 410-141-3830 and the individual program chapter 410 OARs, including chapter 410 Division 151 for Early and Periodic Screening, Diagnostic and Treatment (EPSDT). 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.¶
(2) The Health Systems Division (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);~~meet any of the following:¶
(~~b~~a) 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~~b) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within their scope of practice or licensure;¶
(~~d~~c) 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~~d) Provided by friends or relatives of eligible clients or members of ~~t~~his or hei~~r~~ 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~~e) 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~~f) 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~~g) 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~~h) 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~~i) 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~~j) 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;¶
(~~l~~k) 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~~L) Whose primary intent is to improve appearances, exceptions subject to the HERC coverage and guidelines;¶

(~~n~~m) Similar or identical to services or items that ~~sha~~will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client ~~sha~~will be essentially the same;¶
(~~o~~n) For the purpose of establishing or reestablishing fertility or pregnancy;¶
(~~p~~o) Items or services that are for the convenience of the client and are not medically or dentally appropriate;¶
(~~q~~p) 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~~q) Educational or training classes that are not intended to improve a medical condition;¶
(~~s~~r) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;¶
(~~t~~s) Post-mortem exams or burial costs;¶
(~~u~~t) Radial keratotomies;¶
(~~v~~u) Recreational therapy;¶
(~~w~~v) 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~~w) 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~~x) 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~~y) Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;¶
(~~aa~~z) Missed appointments, an appointment that the client fails to keep. Refer to OAR 410-120-1280;¶
(~~bb~~aa) Transportation to meet a client's personal choice of a provider;¶
(~~cc~~bb) Alcoholics Anonymous (AA) and other self-help programs;¶
(~~dd~~cc) 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~~dd) 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

AMEND: 410-120-1260

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Need to include use of the agreement to pay form as the written documentation

CHANGES TO RULE:

410-120-1260
Provider Enrollment ¶

(1) This rule applies to providers ~~enrolled with or seeking to enroll with the Oregon Health Authority (Authority), Health Systems Division (Division).¶~~
~~(2) Providers signing the Provider Enrollment Agreement constitute agreement to comply with all applicable Division provider rules and federal and state laws and regulations.¶~~
~~(3) Providers enrolled by the Division include:¶~~
~~(a) A non-payable provider, meaning a provider who is issued a provider number for purposes of data collection or non-claims-use such as, but not limited to:¶~~
~~(A) Ordering or referring providers whose only relationship with the Division is to order, refer, or prescribe services for Division clients;¶~~
~~(B) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;¶~~
~~(C) An encounter only provider contracted with a PHP or CCO.¶~~
~~(b) A payable provider, meaning a provider who is issued a provider number for submitting health care claims for reimbursement from the Division. A payable provider may be:¶~~
~~(A) The rendering provider;¶~~
~~(B) An individual, agent, business, corporation, clinic, group, institution, or other entity that in connection with the submission of claims receives or directs the payment on behalf of a rendering provider.¶~~
~~(4) When an entity is receiving or directing payment on behalf of the rendering provider, the billing provider must:¶~~
~~(a) Meet one of the following standards as applicable:¶~~
~~(A) Have a relationship with the rendering provider described in 42 CFR 447.10(g) and have the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider;¶~~
~~(B) Is a contracted billing agent or billing service enrolled with the Division to provide services with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f).¶~~
~~(b) Maintain and make available to the Division upon request records indicating the billing provider's relationship with the rendering provider. This includes:¶~~
~~(A) Identifying all rendering providers for whom they bill or receive or direct payments at the time of enrollment;¶~~
~~(B) Notifying the Division within 30 days of a change to the rendering provider's name, date of birth, address, Division provider numbers, NPIs, Social Security Number (SSN), or the Employer Identification Number (EIN).¶~~
~~(c) Prior to submission of any claims or receipt or direction of any payment from the Division, obtain signed confirmation from the rendering provider that the billing entity or provider is authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be maintained in the provider's files for at least five years following the submission of claims or receipt or direction of funds from the Division.¶~~
~~(5) In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements for providers:¶~~
~~(a) The Division requires non-payable and payable providers to be enrolled consistent with the provider enrollment process described in this rule;¶~~
~~(b) If the rendering provider uses electronic media to conduct transactions with the Division or authorizes a non-payable provider, e.g. billing service or billing agent, to conduct such electronic transactions, the rendering provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a payable or non-payable provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims.¶~~
~~(6) To be enrolled and able to bill as a provider, an individual or organization must:¶~~
~~(a) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules;¶~~
~~(b) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services;¶~~

(c) If providing services within the State of Oregon, have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services.¶
(7) An Indian Health Service facility meeting enrollment requirements shall be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.¶
(8) An individual or organization that is currently subject to sanction by the Division, another state's Medicaid program, or the federal government is not eligible for enrollment (see OAR 410-120-1400, 943-120-0360, Provider Sanctions).¶
(9) All providers must meet the following requirements before the Division may issue or renew a provider number and must provide documentation at any time upon written request by the Division:¶
(a) The provider must disclose to the Division:¶
(A) The identity of any person employed by the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the CHIP program in the last ten years;¶
(B) If the provider is an entity other than an individual practitioner or group of practitioners, disclose the following:¶
(i) The name, date of birth, address, and tax identification number of each person with an ownership or controlling interest in the provider or in any subcontractor in which the provider has a direct or indirect ownership interest of 5 percent or more. When disclosing tax identification numbers:¶
(I) For corporations, use the federal Tax Identification Number;¶
(II) For individuals in a solo practice or billing as an individual practitioner, use the Social Security Number (SSN);¶
(III) All other providers use the Employer Identification Number (EIN);¶
(IV) The SSN or EIN of the rendering provider may not be the same as the Tax Identification Number of the billing provider;¶
(V) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN's and EIN's provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.¶
(ii) Whether any of the persons so named:¶
(I) Is related to another as spouse, parent, child, sibling, or other family members by marriage or otherwise; and¶
(II) Has an ownership or controlling interest in any other entity.¶
(C) A provider must submit within 35 days of the date of a request full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period ending on the date of the request.¶
(b) The provider must submit the following information to the Division:¶
(A) For non-payable providers, a complete Non-Paid Provider Enrollment Request;¶
(B) For payable providers, a complete Provider Enrollment Request, Provider Enrollment Attachment, Disclosure Statement, and Provider Enrollment Agreement;¶
(C) Application fee if required under 42 CFR 455.460;¶
(D) Consent to criminal background check when required;¶
(E) To fulfill federal provider screening requirements pursuant to 42 CFR 455.436 and upon request, the name, date of birth, address, Division provider numbers, NPIs, and Social Security Number (SSN) of any provider who is enrolled or seeking enrollment with the Division.¶
(c) Loss of the appropriate licensure or certification shall result in immediate disenrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;¶
(d) Enrolled providers must notify the Division in writing of material changes in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including, but not limited to, those listed in this subsection:¶
(A) Failure to notify the Division of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual rendering providers may result in the imposition of a $50 fine:¶
(i) If the Division notifies a provider about an error in their Federal Tax Identification, including Social Security Numbers or Employer Identification Numbers for individual rendering providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division's notice.¶
(ii) Failure to comply with this requirement may result in the Division imposing a fine of $50 for each such notice. Federal Tax Identification requirements described in this rule refer to any such requirements established by the Internal Revenue Service.¶
(B) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and

~~controlling information, or criminal convictions may require the submission of a provider enrollment form, provider enrollment agreement, provider certification, or other related documentation;¶~~
~~(C) In the event of bankruptcy proceedings, the provider shall notify immediately the Division administrator in writing;¶~~
~~(D) Claims submitted by or payments made to providers who have not furnished the notification required by this rule or to a provider that fails to submit a new application as required by the Division under this rule may be denied or recovered.¶~~
~~(10) Rendering providers may be enrolled retroactive to the date services are provided to an Division client only if:¶~~
~~(a) The provider is appropriately licensed, certified, and otherwise meets all Division requirements for providers at the time services are provided;¶~~
~~(b) Services are provided fewer than 12 months prior to the date the application for provider status is received by the Division as evidenced by the first date stamped on the paper claim submitted with the application materials for those services, either manually or electronically.¶~~
~~(11) The Division reserves the right to retroactively enroll the provider prior to the 12-month period based upon extenuating circumstances outside the control of the provider, consistent with federal Medicaid regulations, and with approval of the Division's Provider Enrollment Unit Manager.¶~~
~~(12) There are two types of provider numbers:¶~~
~~(a) The Division issues Oregon Medicaid provider numbers to establish an individual or organization's enrollment as an Oregon Medicaid provider:¶~~
~~(A) This number designates specific categories of services covered by the Division Provider Enrollment Attachment. For example, a pharmacy provider number applies to pharmacy services but not to durable medical equipment, which requires a separate provider application attachment and establishes a separate Oregon Medicaid provider number;¶~~
~~(B) For providers not subject to NPI requirements, this number is the provider identifier for billing the Division.¶~~
~~(b) The Division requires compliance with NPI requirements in 45 CFR Part 162. For providers subject to NPI requirements:¶~~
~~(A) The NPI and taxonomy codes are the provider identifier for billing the Division;¶~~
~~(B) Currently enrolled providers that obtain a new NPI are required to update their records with the Division's Provider Enrollment Unit;¶~~
~~(C) Provider applicants must obtain an NPI and include it in their provider enrollment request to the Division.¶~~
~~(13) Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A,655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.¶~~
~~(a) The PDMP check does not apply to clients in exempt populations:¶~~
~~(A) Individuals receiving hospice;¶~~
~~(B) Individuals receiving palliative care;¶~~
~~(C) Individuals receiving cancer treatment;¶~~
~~(D) Individuals with sickle cell disease; and¶~~
~~(E) Residents of a long-term care facility, of a facility described in 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w-3a(h)(2)(B); and ¶~~
~~(F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.¶~~
~~(b) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.¶~~
~~(14) Providers of services outside the State of Oregon shall be enrolled as a provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:¶~~
~~(a) The provider is appropriately licensed or certified and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid programs or exclusion from any other federal or state health care program is a basis for disenrollment, termination, or suspension from participation as a provider in Oregon's medical assistance programs;¶~~
~~(b) The Division shall enroll only an out-of-state non-contiguous pharmacy as a provider when enrollment is necessary to meet a need that cannot be met by an in-state pharmacy. The pharmacy is required to be licensed in the state they are doing business where the client filled the prescription and must be enrolled with the Division in order to submit claims. Identified needs include but are not limited to the following:¶~~
~~(A) Enrollment is necessary to reimburse an out-of-state pharmacy for services rendered to a client that travels out of Oregon and is unable to use a pharmacy licensed in Oregon. The out-of-state pharmacy must be licensed in the state where the services are rendered;¶~~
~~(B) Enrollment is necessary to ensure the Division is the payer of last resort, such as when a client's TPL payer requires use of an out-of-state mail order pharmacy;¶~~

(C) Enrollment is necessary to ensure access to covered pharmacy services that are not otherwise generally available either through the Division's contracted mail order pharmacy or through enrolled in-state pharmacies;¶
(D) Enrollment is necessary to ensure access to covered pharmacy services provided to clients residing in a licensed in-state facility, such as a long-term care facility. The out-of-state pharmacy and the enrollment is limited to services provided to residents of the in-state facility.¶
(c) The provider bills only for services provided within the provider's scope of licensure or certification;¶
(d) For noncontiguous out-of-state providers, the services provided must be authorized in the manner required under these rules for out-of-state services (OAR 410-120-1180) or other applicable Division rules:¶
(A) The services provided are for a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous area of Oregon; or¶
(B) Services provided are for foster care or subsidized adoption children placed out of state; or¶
(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) clients;¶
(D) The services for which the provider bills are covered services under the Oregon Health Plan (OHP).¶
(e) Facilities including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities shall be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by the State of Oregon;¶
(f) Out-of-state providers may provide contracted services per OAR 410-120-1880;¶
(g) Out-of-state billing providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 943-120-0320(15)(f).¶
(15) When a substitute physician is retained to take over another physician's professional practice while he or she is absent or unavailable, the following shall apply:¶
(a) The Division recognizes that absentee physicians may retain substitute physicians as a locum tenens or as part of a reciprocal billing arrangement. For purposes of this rule:¶
(A) A "locum tenens" means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.;¶
(B) A locum tenens may not be retained to take over a deceased physician's professional practice without becoming enrolled with the Division;¶
(C) A "reciprocal billing arrangement" means a substitute physician retained on an occasional basis.¶
(b) Substitute physicians are not required to enroll with the Division; however, the Division may enroll such providers at the discretion of the Division's provider enrollment manager if the provider submits all information required for provider enrollment as described in this rule;¶
(c) In no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;¶
(d) The absentee physician must be an enrolled Division provider and must bill with their individual Division assigned provider number and receive payment for covered services provided by the substitute physician:¶
(A) Services provided by the locum tenens must be billed with a modifier Q6;¶
(B) Services provided in a reciprocal billing arrangement by the substitute physician must be billed with a modifier Q5;¶
(C) In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection and are services for which the absentee physician is authorized to submit a claim;¶
(D) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.¶
(e) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the practice or group name;¶
(f) Nothing in this rule prohibits physicians sharing call responsibilities from opting out of the substitute provider arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled rendering providers and as long as duplicate claims for services are not submitted.¶
(16) Provider termination:¶
(a) The provider may terminate enrollment at any time. The request must be in writing and signed by the provider. The notice shall specify the Division assigned provider number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;¶
(b) The Division may terminate or suspend providers when a provider fails to meet one or more of the

~~requirements governing a provider's participation in Oregon's medical assistance programs such as, but not limited to:¶~~
~~(A) Breaches of provider agreement;¶~~
~~(B) Failure to submit timely and accurate information as requested by the Division;¶~~
~~(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;¶~~
~~(D) Failure to permit access to provider locations for site visits;¶~~
~~(E) Failure to comply with federal or state statutes and regulations or policies of the Division that are applicable to the provider;¶~~
~~(F) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;¶~~
~~(G) Any person who has an ownership or controlling interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP, or the Title XX services program in the last ten years;¶~~
~~(H) Failure to fully and accurately make any disclosure required under this section (9) of this rule.¶~~
~~(17) If a provider's enrollment in the OHP program is denied, suspended, or terminated or a sanction is imposed under this rule, the providers may request a contested case hearing pursuant to OAR 410-120-1600 and 410-120-1860.¶~~
~~(18) The provision of health care services or items to Division clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service~~requesting enrollment, currently enrolled, and previously enrolled with the Oregon Health Authority (Authority), Health Systems Division (Division).¶
(2) Providers signing the Provider Enrollment Agreement constitute agreement to comply with all applicable Authority provider rules, Oregon Department of Human Services (ODHS) provider rules, and federal and state laws and regulations applicable to Medicaid payments.¶
(3) Authority review of a provider application for enrollment, material change in a provider's enrollment information, and any documentation received in response to an Authority re-validation request is based on a categorical risk level of limited, moderate, or high. If a provider falls within more than one risk level described in 42 CFR 455.450, the highest level of review is conducted by Authority. Authority will assign a risk level which meets or exceeds federal requirement and reserves the right to adjust provider risk level at any time when:¶
(a) Authority imposes a payment suspension, in accordance with OAR 410-120-1400, on a provider based on credible allegation of fraud, waste or abuse;¶
(b) The provider has an existing Medicaid overpayment which, including all outstanding depts and interest, is $1,500 or greater and all of the following:¶
(i) Is more than 30 calendar days old;¶
(ii) Has not been repaid at the time the application for enrollment is filed;¶
(iii) Is not currently being appealed; and¶
(iv) Is not part of an Authority approved extended repayment schedule for the entire outstanding overpayment.¶
(c) The provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous 10 years; or¶
(d) Authority or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type, in compliance with 42 CFR 455.470 and 42 CFR 424.570, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.¶
(4) Authority, CMS, its agents, or its designated contractors may, in accordance with 42 CFR 455.432, conduct pre- and post-enrollment on-site visits and unannounced inspections of any and all provider locations at any time, for all provider types.¶
(5) Providers enrolled by the Authority include:¶
(a) A non-billing provider, meaning a provider who is issued a provider number for purposes of screening, data collection or non-claims-use such as, but not limited to:¶
(A) Ordering or referring providers, required by 42 CFR 455.410, whose only relationship with the Authority is to order, refer, or prescribe services for Authority members;¶
(B) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;¶
(C) An encounter only provider contracted with and credentialed by a MCE, as required by OAR 410-141-3510.¶
(b) A payable provider, meaning a provider who is issued a provider number for submitting health care claims for reimbursement from the Authority. A payable provider may be:¶
(A) The rendering provider;¶
(B) An individual, agent, business, corporation, clinic, group, institution, or other entity that in connection with the submission of claims or encounters receives or directs the payment on behalf of a rendering provider.¶
(6) When a payable provider is receiving or directing payment on behalf of the rendering provider, the payable

provider must:¶
(a) Meet one of the following standards:¶
(A) Have a relationship with the rendering provider described in 42 CFR 447.10(g) and have the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider; and¶
(B) Is a contracted billing agent or billing service enrolled with the Oregon Health Authority to provide services with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f).¶
(b) Maintain and provide to the Authority upon request records indicating the billing provider's relationship with the rendering provider. This includes:¶
(A) Identifying all rendering providers for whom they bill or receive or direct payments at the time of enrollment;¶
(B) Notifying the Authority within 30 days using Authority forms of a change to the rendering provider's enrollment record such as name, date of birth, address, Authority assigned provider numbers, National Provider Identification Numbers (NPI), Social Security Number (SSN), or the Employer Identification Number (EIN); and¶
(C) The authorization to direct payment, signed by the rendering provider.¶
(c) Prior to submission of any claims or receipt or direction of any payment from the Authority , obtain signed confirmation from the rendering provider that the billing entity or provider is authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be signed by the rendering provider and maintained in the provider's files for at least seven (7) years following the submission of claims or receipt or direction of funds from the Authority.¶
(7) To facilitate timely claims and encounter processing and payment consistent with applicable privacy and security requirements for providers:¶
(a) The Authority requires all non-billing and payable providers to be enrolled consistent with the provider enrollment process described in this rule;¶
(b) If the provider uses electronic media to conduct transactions with the Authority or authorizes a non-billing provider, e.g. billing service or billing agent, to conduct such electronic transactions, the rendering provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a payable or non-billing provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims; and¶
(c) The claims and encounters submitted to the Authority must include an NPI for each provider subject to the NPI requirements in 45 CFR Part 162 Subpart D. Rendering and referring providers may not have the same NPI listed on the claim or encounter. Billing and rendering providers may not have the same NPI listed on the claim or encounter.(9) To be enrolled and able to bill and receive payment as a provider, an individual or organization must:¶
(A) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules. The provider's license must be active. Authority may deny enrollment, re-enrollment or revalidation when a provider's licensing body has placed limitations on the provider's license or an action that created a limitation on the provider's license impacts the quality or safety of services provided to OHP members. The Authority may request additional documentation from the provider or the licensing body or require additional screening.¶
(B) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services. This includes meeting all applicable national and state licensure and certification requirements for all employees, subcontractors, vendors or other third parties providing services to Medicaid members for which the enrolled provider is receiving reimbursement from Authority;¶
(C) If providing services within Oregon, have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services; and¶
(D) Comply with all requests from Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) for records and information when MFCU determines it is necessary to carry out its responsibilities. The records and information must be provided without charge and in the form requested by MFCU. A provider must comply with a request from MFCU for access to any records and information kept by providers to which OHA, ODHS, MCEs and MFCUs are authorized access by 42 CFR s431.107, including, but not limited to, any records necessary to disclose the extent of services provided to beneficiaries and any information regarding payments claimed by the provider for furnishing said services. The records and information must be provided without charge and in the form requested by MFCU. When a MFCU request for access is made in person such access must be granted immediately. A provider must make available to MFCU, copies of all procedural and policy statements, directives, and proposed or adopted regulations concerning the Medicaid program, and any other information relevant to the work of MFCU. Providers shall disclose protected health care information to the MFCU for oversight activities as authorized by 45 CFR s164.512(d).¶

(8) An Indian Health Service facility meeting enrollment requirements shall be enrolled on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.¶
(9) A provider that is currently subject to sanction by the Authority or the provider, a person with ownership or control of the provider, or a provider's managing employee is excluded, sanctioned or suspended by the federal government or another state from Medicare or Medicaid participation the provider is not eligible for enrollment, consistent with OAR 410-120-1400, ; except when the Agency determines good cause exists, in accordance with 42 CFR 455.23;¶
(10) All providers listed in section (5) of this rule must provide the following information before the Authority may enroll and issue or revalidate an Authority assigned provider number. Information disclosed by the provider is subject to verification by Authority and all providers must provide documentation at any time upon written request by the Authority:¶
(a) The provider must disclose to the Authority the name, federal Tax Identification Number (TIN), date of birth, primary business address, every business location and P.O Box address of the provider and, as applicable, for the following:¶
(A) Each person who has a direct or indirect ownership or control interest in the provider, is an agent or is a managing employee of the provider, regardless of whether that person is an individual or corporate entity;¶
(B) Each person who has a direct or indirect ownership or control interest in the provider, is an agent or is a managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the CHIP program in the last ten years;¶
(C) Any subcontractor in which the provider has a direct or indirect ownership interest of five (5) percent or more.¶
(D) For the purpose of this rule, a person with direct or indirect ownership or control interest is defined in 42 CFR 455.101 and Authority calculates ownership and control percentage as required by 42 CFR 455.102. ¶
(E) When disclosing tax identification numbers:¶
(i) For corporations, use the federal TIN;¶
(ii) For individuals use the Social Security Number (SSN);¶
(iii) All other providers use the EIN;¶
(iv) The SSN or EIN of the rendering provider may not be the same as the Tax Identification Number of the billing provider;¶
(v) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN and EIN provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.¶
(F) Whether any of the persons so named with an ownership or control interest in the provider requesting enrollment:¶
(i) Is related to another person with ownership or controlling interest in the provider requesting enrollment as a spouse, parent, child, sibling, or other family members by marriage or otherwise; and¶
(Iii) The name of any other current or former Medicaid providers in which an owner of the provider requesting enrollment has an ownership or control interest.¶
(G) A provider shall submit, within 35 calendar days of the date of a request by the Authority full and complete information about:¶
(i) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and¶
(ii) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.¶
(H) Failure to disclose or submit required information: Authority may not reimburse a provider for services furnished in the period beginning the day following the date the information was due to the Authority and ending on the day before the date on which the information was supplied. Authority will suspend or terminate the provider's enrollment and Authority assigned provider number, in accordance with 42 CFR 455.104.¶
(b) The provider must submit required information to the Authority:¶
(A) Provider enrollment application based on the type of provider, Provider Enrollment Agreement, Provider Disclosure Statement, and all Attachments. Authority only accepts current versions of enrollment forms. All required forms are available at all times on OHA's Provider Enrollment website;¶
(B) Application fee if required under 42 CFR 455.460;¶
(C) Consent to criminal background check to complete Authority established screening process and comply with 42 CFR § 455.410 and § 455.450 requirements for provider categories which pose increased financial risk of fraud, waste or abuse to the Medicaid program, 42 CFR § 455.434 when required;¶
(D). The Authority may use Medicare provider enrollment data to satisfy the requirement of (12)(b)(C), in this rule;

and¶
(E) Copy of provider's license, certification, or both.¶
(11) Authority may screen providers and validate information disclosed by providers as required under 42 CFR 455.436. Authority reserves the right to conduct and review providers requesting enrollment or revalidation in a more stringent manner than Medicare or other state Medicaid programs, conduct additional screening, or impose additional requirements on providers, or all three, for a provider or a group of providers identified by the Authority as at increased risk for fraud, waste or abuse.¶
(12) Authority may at its sole discretion require providers to enroll as a Medicare provider prior to enrolling in Oregon's Medicaid program.¶
(13) Authority may implement 180-day moratoriums on the enrollment of providers in a specific service category, on a statewide basis, or within a specific Oregon geographic area, when the Authority determines the action is necessary to safeguard public funds or to maintain the fiscal integrity of the Oregon Medicaid program.¶
(14) Provider enrollment and the signed Provider Enrollment Agreement expires five (5) years from the date of enrollment. Authority will revalidate all enrolled providers at least every five (5) years, compliant with 42 CFR 455.414. Authority reserves the right to revalidate more frequently, at its discretion. Failure of a provider to respond to Authority notice or failure to return requested information for revalidation will result in termination of the provider enrollment agreement and Authority assigned provider number.(17) Enrolled providers shall notify the Authority in writing using Authority forms within 35 calendar days of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including, but not limited to, those listed in this subsection:¶
(a) Changes in federal TIN, SSN or EIN. Failure to notify the Authority of a change of Federal TIN for entities or a SSN, or EIN for individual providers may result in the imposition of a $50 fine per incident:¶
(b) Changes in business service location, affiliation, ownership, NPI, ownership and control information, or criminal convictions. The provider must notify the Authority using Agency provided forms;¶
(c) Providers who have more than one (1) NPI or receive a new NPI after enrolling with the Authority must complete a separate enrollment with the Authority for each NPI prior rendering services or listing the NPI on claims or encounters submitted to Authority.¶
(d) Bankruptcy proceedings, the provider shall immediately notify the Authority Provider Enrollment Unit in writing;¶
(e) Claims submitted by or payments made to providers who have not furnished the notification required by this rule or to a provider that fails to submit a new application as required by the Division under this rule may be denied or recovered.¶
(15) If Authority notifies the provider of an error in the federal TIN, the provider must supply the appropriate valid federal TIN within 35 calendar days of the date of Authority's notice. Failure to comply with this requirement may result in Authority imposing a fine of $50 for each such notice. Federal TIN requirements described in this rule refer to any such requirements established by the Internal Revenue Service.¶
(16) Providers upon request may be enrolled by Authority up to 12 months prior to the date application for enrollment is received by the Authority only if:¶
(a) The provider is appropriately licensed, certified, and otherwise meets all federal and Authority requirements for providers at the time services are provided;¶
(b) The MCE submits to the Authority all required documentation to enroll the provider as an encounter only provider and that provider has an executed contract with and has successfully completed a credentialing process with the MCE;¶
(c) Upon request, the provider or MCE must submit to Authority a clear written statement as to why retro-enrollment is necessary to increase access to care and advance the triple aim.¶
(17) The Authority requires two types of provider numbers:¶
(a) The Authority issued Oregon Medicaid provider number which establishes an individual or organization's enrollment as an Oregon Medicaid provider:¶
(A) The Provider Enrollment Agreement and the provider's enrollment as an Oregon Medicaid provider is specific to the provider type and specialty type listed on the application for enrollment and constitutes a contractual relationship with the Authority. This Authority assigned number designates the specific categories of services covered by the Authority Provider Enrollment Agreement. For example, a pharmacy provider number applies to pharmacy services and cannot be used by the provider provide or bill for durable medical equipment.¶
(B) A provider seeking to render services or bill as more than one provider type shall complete a separate provider application and establish a separate Oregon Medicaid provider number;¶
(C) For providers not subject to NPI requirements, this Authority issued number is the provider identifier for billing the Authority.¶
(b) The Authority requires a National Provider Identification (NPI) in compliance with 45 CFR Part 162 Subpart D, for providers subject to NPI and Taxonomy requirements, as enumerated by the National Plan and Provider

Enumeration System (NPPES). A provider must obtain an NPI and Taxonomy code prior to requesting enrollment and include these numbers in the application to request enrollment. The NPPES NPI information and provider applications are available at all times online: https://nppes.cms.hhs.gov/#/. For providers subject to NPI requirements:¶
(A) The NPI is the provider identifier for billing the Authority. The Provider Enrollment Agreement and the provider's enrollment as an Oregon Medicaid provider is specific to the NPI listed on the application for enrollment and constitutes a contractual relationship with the Authority;¶
(B) Providers currently enrolled that obtain a new or additional NPI shall complete a new application for provider enrollment with the Division's Provider Enrollment Unit and the application must be approved by the Authority prior to the provider rendering or billing for services associated with that NPI;¶
(18) Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A.655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.¶
(a) The PDMP check does not apply to clients in exempt populations:¶
(A) Individuals receiving hospice;¶
(B) Individuals receiving palliative care;¶
(C) Individuals receiving cancer treatment;¶
(D) Individuals with sickle cell disease; and¶
(E) Residents of a long-term care facility, of a facility described in 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w-3a(h)(2)(B); and¶
(F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.¶
(b) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.¶
(19) Providers of services outside of Oregon shall be enrolled as a provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:¶
(a) The provider is appropriately licensed or certified in the state in which the provider is located and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid programs or exclusion from any other federal or state health care program is a basis for disenrollment, termination, or suspension from participation as a provider in Oregon's medical assistance programs;¶
(b) The provider bills only for services provided within the provider's scope of licensure or certification;¶
(c) For noncontiguous out-of-state providers, the services provided must be authorized in the manner required under OAR Ch 410 and Ch 309 rules specific to the service, OAR 410-120-1180 and these rule for out-of-state services:¶
(A) The services provided are for a specific Oregon Medicaid member who is temporarily outside Oregon or the contiguous area of Oregon;¶
(B) Services provided are for foster care or subsidized adoption children placed out of state; or¶
(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) members; or¶
(D) The services for which the provider bills are covered services under the Oregon Health Plan (OHP) and follow Authority requirements for prior authorization, when applicable.¶
(d) Facilities including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities shall be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by Oregon;¶
(e) Out-of-state providers may provide contracted services per OAR 410-120-1880; and¶
(f) Out-of-state entities seeking to enroll, or enrolled, as a billing provider shall register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to ORS 63.701 and OAR 410-120-1260.¶
(g) The Authority shall enroll an out-of-state noncontiguous pharmacy as a provider only when enrollment is necessary to meet a need that cannot be met by an in-state pharmacy. The pharmacy is required to be licensed in the state where the member filled the prescription (i.e. state where medication is dispensed) and must be enrolled with the Authority as a Medicaid provider in order to submit claims or encounters to Authority. Identified needs include but are not limited to the following:¶
(A) Enrollment is necessary to reimburse an out-of-state pharmacy for services rendered to a member that travels out of Oregon and is unable to use a pharmacy licensed in Oregon. The out-of-state pharmacy must be licensed in the state where the services are rendered;¶
(B) Enrollment is necessary to ensure the Authority is the payer of last resort, OAR 410-120-1280, such as when a member's TPL payer requires use of an out-of-state mail order pharmacy;¶
(C) Enrollment is necessary to ensure access to covered pharmacy services that are not otherwise generally

available either through the Authority's contracted mail order pharmacy or through enrolled in-state pharmacies; or¶
(D) Enrollment is necessary to ensure access to covered pharmacy services provided to members residing in a licensed in-state facility, such as a long-term care facility. The out-of-state pharmacy and the enrollment is limited to services provided to residents of the in-state facility.¶
(20) Termination of provider enrollment and the Authority assigned provider number:¶
(a) The provider may terminate enrollment at any time. The request shall be in writing and signed by the provider. The notice shall specify the Authority assigned provider number to be terminated and the effective date of termination. Termination or deactivation of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;¶
(b) The Authority may deny enrollment, revalidation, or re-enrollment, or sanction and suspend or terminate a provider at any time including but not limited to any of the reasons listed in OAR410-120-1400; and¶
(c) Authority will send written notice to the provider when a provider's application for enrollment, revalidation or re-enrollment is denied, enrollment is terminated or suspended, or a sanction is imposed by Authority under OAR 410-120-1400, regardless of whether the provider is continuously enrolled, or the provider number is active at the time notice is issued. Authority notice will state the effective date of the Action.¶
(21) A provider may appeal a termination, suspension or other sanction. If a provider's enrollment, revalidation, or re-enrollment is denied, enrollment is suspended, terminated or any sanction is imposed by the Authority under this rule, the provider may request a contested case hearing pursuant to OAR 410-120-1400, 410-120-1460, 410-120-1600 and 410-120-1860.¶
(22) If a provider's enrollment is suspended or terminated, the Authority may notify board of registration or licensure, federal or other state Medicaid agencies, MCEs and the National Practitioner Data Base of the finding(s) and the sanction(s) imposed.¶
(23) If a provider's enrollment has been deactivated, terminated or suspended for any reason the provider must complete a new application for enrollment, including all required documentation, and submit it to the Authority. To re-enroll the provider, Authority review is contingent upon the risk-based screening in section (3) of this rule. A re-enrollment by Authority has the same requirements and process as a new enrollment.¶
(24) Authority may deny enrollment, revalidation or re-enrollment request (for encounter purposes) to an encounter only provider, or sanction and suspend or terminate an enrolled encounter only provider, for any of the reasons in OAR 410-120-1400:¶
(a) Authority will notify the encounter only provider and the MCE. Authority notice will state the effective date of the Action;¶
(b) Authority may recoup any overpayments in accordance with OAR Ch 410, Div. 120, CH 410 Div. 141, and the contract between the MCE and the Authority; and¶
(c) The MCE must adjust encounter claims in accordance with OAR 410-141-3570 and recoup overpayments from the provider in accordance with OAR 410-141-3510.¶
(25) The provision of health care services or items to Authority members is a voluntary action on the part of the provider. Providers are not required to serve all Authority members seeking service.¶
(26) Providers seeking to enroll in the Authority must be a provider type established in the State Plan as approved for Medicaid reimbursement.¶
[NOTE: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-120-1340

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Updating Rate

CHANGES TO RULE:

410-120-1340
Payment ¶

(1) The Division shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.¶
(2) Division reimbursement for services may be subject to review prior to reimbursement.¶
(3) The Division sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.¶
(4) The Division reimburses providers for billed services or items at the lesser of:¶
(a) The amount billed;¶
(b) The Division's FFS payment rate in effect on the date of service; or¶
(c) The rate specified in the individual program provider rules.¶
(5) The amount billed may not exceed the provider's "usual charge" (see definitions 410-120-0000).¶
(6) The Division's maximum allowable rate setting process uses the following methodology for:¶
(a) Relative Value Unit (RVU) weight-based rates. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register:¶
(A) The Division applies RVU weights as follows:¶
(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;¶
(ii) The Facility Total RVU weight, to professional services typically performed in a facility.¶
(B) The Division applies the following conversion factors:¶
(i) $40.79 for labor and delivery codes (59400-59622);¶
(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99468-99480);¶
(iii) $~~27.82~~8.50 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;¶
(iv) $25.48 for all remaining RVU weight-based CPT/HCPCS codes.¶
(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:¶
(i) (Work RVU) X (Work GPCI) + (Practice Expense RVU) X (Practice GPCI) + (Malpractice RVU) X (Malpractice GPCI). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.¶
(ii) The sum in paragraph (C)(i) is multiplied by the applicable conversion factor in section (B) to calculate the rate;¶
(b) Non-RVU-weight-based rates:¶
(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;¶
(B) Clinical lab codes are 70 percent of the Medicare clinical lab fee schedule effective on the date of service;¶
(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule effective on the date of service;¶
(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate. The Medicare rate is equal to Average Sales Price (ASP) plus six percent;¶
(c) When no ASP rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;¶
(d) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;¶
(e) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;¶
(f) Individual provider rules may specify rates for particular services or items.¶
(7) The Division reimburses inpatient hospital services under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.¶
(8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the hospital has a contract or service

agreement with the Division to provide highly specialized services.¶
(9) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.¶
(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:¶
(a) Consistent with the rate for similar services provided in Oregon; and¶
(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or¶
(c) Consistent with the rate established by APD for out-of-state nursing facilities.¶
(11) The Division may not make payment on the following claims:¶
(a) Assigned, sold or otherwise transferred claims; or¶
(b) Claims where the billing provider, billing agent, or billing service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a provider for accounts receivable.¶
(12) Nursing facility payments:¶
(a) The Division may not make a separate payment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).¶
(b) The following services are not in the all-inclusive rate and may be reimbursed separately:¶
(A) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services program administrative rules (chapter 410, division 148);¶
(B) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);¶
(C) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);¶
(D) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);¶
(E) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);¶
(F) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);¶
(G) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).¶
(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.¶
(14) For payment for Division clients with Medicare and full Medicaid:¶
(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;¶
(b) The Division pays the allowable rate for covered services that are not covered by Medicare.¶
(15) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.¶
(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. For the Division, payment in full includes:¶
(a) Zero payments for claims when a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and¶
(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.¶
(17) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.
Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742, 414.743

AMEND: 410-120-1360

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: Routine services for clinical trials – following HSD adding these services in 2022, OPI recommended several updates to Sec. 1360. The goal of these updates was to ensure OPI can access to the documents/records needed/necessary for auditing these types of services. Because HSD did not create new rule section in Div. 120 (or any other div. of OAR CH 410) for these types of services the request from OPI was to use Sec. 1360 (general recordkeeping).

CHANGES TO RULE:

410-120-1360
Requirements for Financial, Clinical and Other Records ¶

(1) The Authority shall analyze, monitor, audit, and verify the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, quality of care, and access to care of the Medical Assistance Programs and the Children's Health Insurance Program.¶
(2) The provider or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records shall develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested. Payment shall be made only for services that are adequately documented. Documentation shall be completed before the service is billed to the Division and meet the following requirements:¶
(a) All records shall document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service is provided, and the individual providing the service. Patient account and financial records shall also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported;¶
(b) Clinical records, including records of all therapeutic services, shall document the client's diagnosis and the medical need for the service. The client's record shall be annotated each time a service is provided and signed or initialed by the individual who provided the service or shall clearly indicate the individual who provided the service. For purposes of medical review, the Authority adopts Medicare's electronic signature policy as outlined in the CMS Medicare Program Integrity Manual. Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, the individual provider rules, and any relevant contracts;¶
~~(c) Electronic Data Transmissions shall comply with the Uniform Electronic Transactions Act cited in ORS chapter 84 and OAR 943-120-0100;¶~~
~~(d) Policies and procedures shall ensure the maintenance of the confidentiality of medical record information. These procedures ensure the provider may release information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, and 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50.¶~~
~~(e) Retain clinical records for seven years and financial and other records described in paragraphs (a) and (b) of this rule for at least five years from the date(s) of service~~. When a provider maintains records electronically, within an EHR, EMR or other electronic clinical trial management or billing system, the provider must be able to provide:¶
(A) hard copy versions, upon request; and¶
(B) an auditable means of demonstrating the date the record was created, the identity of the creator of a record, the date the record was modified, what was modified in the record, and the identity and credentials of any individual who has modified the record.¶
(C) If the provider maintains records electronically or permits the use of electronic signatures, the provider must document any aspect of the provision of services. The provider must maintain appropriate safeguards to assure the authenticity of the electronic records and signatures.¶
(c) Electronic Data Transmissions shall comply with the Uniform Electronic Transactions Act cited in ORS chapter 84 and OAR 943-120-0100;¶
(d) Policies and procedures shall ensure the maintenance of the confidentiality of medical record information. These procedures ensure the provider may release information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, and 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50.¶
(e) Retain clinical records for seven years and financial and other records described in paragraphs (a) and (b) of this rule for at least five years from the date(s) of service.¶

(f) Record requirements applicable only to providers who are providing routine services for clinical trials:¶
(A) Information must be retained and provided if requested for medical review, audit or investigation by Authority, DOJ MFCU or other state or federal regulators and shall include:¶
(i) The trial name, sponsor, and sponsor-assigned protocol number (This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov).¶
(ii) A copy of the member's signed consent form¶
(B) Record for clinical trials must be maintained and accessible for 10 years¶
(C) The records be stored and protected compliant with HIPAA and other applicable standards.¶
(3) Upon written request from the Authority, the Medicaid Fraud Control Unit~~,~~ Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives furnish requested documentation immediately or within the time-frame specified in the request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Medicaid ~~Fraud~~Control Unit, or DHHS may review and copy the original documentation in the provider's place of business. Upon the written request of the provider, the program or the unit may, at their sole discretion, modify or extend the time for providing records if, in the opinion of the program or unit good cause for an extension is shown. Factors used in determining whether good cause exists include:¶
(a) Whether the written request was made in advance of the deadline for production;¶
(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;¶
(c) The efforts already made to comply with the request;¶
(d) The reason~~s the deadline cannot be met~~(s) for not meeting the deadline;¶
(e) The degree of control that the provider had over its ability to produce the records prior to the deadline;¶
(f) Other extenuating factors.¶
(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the client if the purpose is:¶
(a) To perform billing review activities;¶
(b) To perform utilization review activities;¶
(c) To review quality, quantity, and medical appropriateness of care, items, and services provided;¶
(d) To facilitate payment authorization and related services;¶
(e) To investigate a client's contested case hearing request;¶
(f) To facilitate investigation by the Medicaid Fraud Control Unit or DHHS; or¶
(g) Where review of records is necessary to the operation of the program.¶
(5) Failure to comply with requests for documents within the specified time-frames means that the records subject to the request may be deemed by the Authority not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination may subject the provider to possible denial or recovery of payments made by the Division or to sanctions.¶
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

AMEND: 410-120-1400

NOTICE FILED DATE: 10/08/2023

RULE SUMMARY: HSD process changes due to changes to unit work and evolving CMS requirements for provider enrollment

CHANGES TO RULE:

410-120-1400
Provider Sanctions ¶

(1) The Authority recognizes two classes of Medicaid provider sanctions, mandatory and discretionary, outlined in sections (~~3~~4) and (4~~5~~) ~~below.~~¶
~~(2) Except as otherwise noted, the Authority shall impose provider sanctions at the discretion of the Authority Director or the Administrator~~of this rule.¶
(2) The Authority shall impose sanctions on Medicaid providers at the discretion of the Authority Director or delegate. Nothing in this rule limits the ability of Authority o~~f~~r the ~~Division whose budget includes payment for the services involved~~Oregon Department of Human Services (ODHS) to also seek monetary recovery, or pursue remedies specific to a contract with Authority or ODHS, or as otherwise permitted by state or federal law. Authority sanctions of its contracted managed care entities are governed by OAR 410-141-3530.¶
(3) ~~The~~ Authority~~'s Health Systems Division (Division) shall impose mandatory sanctions and suspend the provider from participation in Oregon's medical assistance programs~~ may sanction and suspend or terminate a provider who:¶
(a) is applying for enrollment, re-enrollment or revalidation as an Oregon Medicaid provider;¶
(b) is enrolled as an Oregon Medicaid provider; regardless of whether enrollment is continuous or active; or¶
(c) was an enrolled Oregon Medicaid provider at the time the sanctionable conduct, action, conditions or activity occurred.¶
(4) The Authority shall impose mandatory sanctions and deny enrollment, suspend or terminate the enrollment of the provider from participation in Oregon's medical assistance programs, regardless of whether the provider was directly enrolled or contracted by Authority or was enrolled or contracted by an Authority designee including but not limited to ODHS:¶
(a) When a provider, ~~of medical services is convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act, or related state laws;¶~~
~~(b) When a provider~~r any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider is, or was in the preceding then (10) years, convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act, any other federal program, or related state laws; regardless of whether an appeal from that judgment is pending;¶
(b) When a provider, or any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider, is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) or from ~~the~~ Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services; regardless of whether an appeal from that judgment is pending. The provider shall ~~be excluded and~~also be terminated or suspended from participation with the ~~Division~~Authority for the duration of exclusion or suspension from the Medicare program or by the O~~ffice of the Inspector General;¶~~
~~(c) If the~~IG;¶
(c) When a provider fails to disclose ownership or controlling information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment application, or when there is a material change in the information that must be reported or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.¶
(4~~d~~) ~~T~~Whe ~~Division may impose discretionary sanctions when the Division determines that~~n a provider, or any person with a five (5) percent or greater direct or indirect ownership or controlling interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the Authority within 30 days of CMS or an Authority request;¶
(e) When a provider, or any person with a five (5) percent or greater direct or indirect ownership or control interest, an agent, affiliate or managing employee of the provider, fails to ~~meet one or more of the Division's requirements governing participation in its medical assista~~submit timely and accurate information, comply with Authority screening methods, or both as required under 42 CFR 455 Subpart E;¶

(f) When a provider fails to permit access to a provider location for any site visit under 42 CFR 455.432; unless the Authority determines the termination is not in the best interest of the Medicaid program. 42 CFR 455.416(f);¶
(g) When a provider is suspended or excluded from participation in a state Medicaid or CHIP program for reasons related to professional competence, programs. Conditions that may result in a discretionary sanction include but are not limited to wfessional performance, debarment or other reason;¶
(h) If the Authority:¶
(A) Determines that the provider has falsified any information provided on the application for enrollment; or¶
(B) Cannot verify the identity of the provider.¶
(i) When a provider is:¶
(a) C convicted of fraud related to any federal, state, or locally financed health care program or commits fraud, receives kickbacks, or commits other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;¶
(b)Cj) When a provider is convicted of interfering with the investigation of health care fraud;¶
(ck) CWhen a provider is convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;¶
(d) By findings orl) When a provider, or any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider, is subject to an adverse Legal Action including conviction of a felony crime against persons, financial crime(s) or misdemeanor conviction of patient abuse or neglect, theft, embezzlement or fraud;¶
(m) When there is a credible allegation of fraud as defined in 42 CFR 455.2 for which an investigation is pending under the Medicaid program, unless good cause not to suspend payments exists, in accordance with 42 CFR 455.23;¶
(n) When Authority receives a referral from a Medicaid Fraud Control Unit (MFCU), Authority will initiate any available administrative or judicial action to recover improper payments to a provider and suspend the provider to prevent future payments, unless good cause not to suspend payments exists, in accordance with 42 CFR 455.23;¶
(o) When the provider's enrollment has been terminated or revoked for cause by Medicare or another state's Medicaid program and such termination has been published in the Data Exchange System (DEX), the Authority will terminate the provider's enrollment in its program pursuant to 42 CFR 455.416(c) and455.101.¶
(5) The Authority may impose discretionary sanctions and deny enrollment, suspend or terminate a provider when the Authority determines that the provider fails to meet one or more of the Authority's requirements in all applicable administrative rules or the contract between Authority and the provider governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include but are not limited to:¶
(a) breech of the provider agreement;¶
(b) actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, quality of care, or financial integrity including but not limited to:¶
(A) Having the health care license suspended or revoked, or otherwise loses their license; or¶
(B) Surrendering their license while a formal disciplinary proceeding is pending before the licensing authority.¶
(ec) Suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;¶
(fd) Billsing excessive charges (i.e., charges more than the usual charge). Furnishes items or services substantially more than the DivisionAuthority client's needs or more than those services ordered by a medical provider or more than generally accepted standards or of a quality that fails to meet professionally recognized standards;¶
(ge) Fails to furnish medically necessary services as required by law or contract with the DivisionAuthority if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the DivisionAuthority client;¶
(hf) Fails to disclose required ownership information;¶
(ig) Fails to supply requested records and information on subcontractors, providers, and suppliers of goods or services;¶
(jh) Fails to supply requested payment information;¶
(k) Fails to grant access or to furnish as requested, records, or grant access to facilities upon request of the Division or the State of Oregon's Medicaid Fraud Uniti) Fails to provide or disclose requested information or documentation to Authority, within the timeframe listed on the Authority's written request;¶
(j) Fails to grant access or to furnish as requested, records, or grant access to facilities upon request of the Authority or designee, ODHS, the Authority's Office of Program Integrity (OPI), OIG, or the State of Oregon's Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) conducting their regulatory or statutory functions;¶
(lk) In the case of a hospital, fails to take corrective action as required by the DivisionAuthority, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or

practice patterns, within the time specified by the ~~Division~~Authority;¶
(~~m~~L) Defaults on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The ~~Division~~Authority:¶
(A) ~~Must~~Shall make a reasonable effort to secure payment;¶
(B) ~~Must~~Shall take into account access of beneficiaries to services; and¶
(C) May not exclude a community's sole physician or source of essential specialized services.¶
(~~n~~m) ~~Repeatedly submits a~~Submits one or more claims with required data missing or incorrect~~:~~;¶
(~~A~~n) ~~When the missing or incorrect data allows the provider to:¶~~
~~(i) Obtain greater payment than is appropriate;¶~~
~~(ii) Circumvent prior authorization requirements;¶~~
~~(iii) Charge more than the provider's usual charge to the general public;¶~~
~~(iv) Receive payments for services provided to persons who are not eligible;¶~~
~~(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount, or type of health care provided.¶~~
~~(B) Fails to comply with the requirements of OAR 410-120-1280 (Billing).¶~~
~~(o) Fails to develop, maintain, and retain in accordance with relevant rules~~Fails to comply with the requirements of OAR 410-120-1280, Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the service or good when billing or submitting claims or encounters to Authority.¶
(o) Fails to develop, maintain, and retain in accordance with OAR 410-120-1360 and relevant rules Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the service or good and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;¶
(p) Fails to develop, maintain, and retain in accordance with ~~relevant rules and standards adequate financial records~~OAR 410-120-1360 and relevant rules in Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the provider and adequate financial records as defined in OAR 410-120-0000 that document charges incurred by a client and payments received from any source;¶
(q) Fails to develop, maintain, and retain adequate financial or other records of all assets, liabilities, income, and expenses that support information submitted on a cost report;¶
(r) Fails to follow generally accepted accounting principles or accounting standards or cost principles sanctioned by recognized authoritative bodies such as the Governmental Accounting Standard Board and the Financial Accounting Standards Board and required by federal or state laws, rules, or regulations applicable to Medicaid;¶
(s) Submits claims or written orders contrary to generally accepted standards of medical practice of the provider receiving or requesting payment;¶
(t) Submits claims or encounters for services that exceed that requested or agreed to by the ~~client~~member or the responsible relative or guardian or requested by another medical provider;¶
(u) Breaches the terms of the provider contract or ~~agreement~~the provider enrollment agreement with the Authority or Oregon Department of Human Services (ODHS). This includes failure to comply with the terms of the provider certifications on the medical claim form;¶
(v) Rebates or accepts a fee or portion of a fee or charge for an ~~Division~~Authority client referral, or collects a portion of a service fee from the client and bills the ~~Division~~Authority for the same service;¶
(w) ~~Submits false or fraudulent information when applying for the Division assigned provider number, or f~~Fails to disclose information requested on the provider enrollment application or as otherwise requested by Authority;¶
(x) Fails to correct deficiencies in operations after receiving written notice of the deficiencies from the ~~Division~~Authority; including deficiencies in licensing or certification procedures;¶
(y) Submits any claim or encounter for payment for which payment has already been made by the ~~Division~~Authority or any other source unless the amount of the payment from the other source is clearly identified;¶
(z) Threatens, intimidates, or harasses ~~client~~members or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the ~~Division~~Authority;¶
(aa) Fails to properly account for a ~~Division client~~n Authority member's Personal Incidental Funds, including but not limited to using a client's Personal Incidental Funds for payment of services that are included in a medical facility's all-inclusive rates;¶
(bb) Provides or bills for services provided by ineligible or unsupervised ~~staff~~or unqualified employees, providers, or interns;¶
(cc) Participates in collusion that results in an inappropriate money flow between the parties involved~~;~~, for example, referring clients unnecessarily to another provider;¶
(dd) Refuses or fails to repay in accordance with an accepted schedule an overpayment established by the ~~Division;¶~~
~~(ee) Fails to report to Division payments received from any other source after the Division made payment for the service;¶~~

~~(ff) Failure to comply with the requirements listed in OAR 410-120-1280(Billing).~~Authority, Authority's OPI, MFCU or as ordered by a court;¶
(ee) Refuses or fails to repay in accordance with an accepted schedule repayment of identified overpayment or settlement agreements established by Authority, Authority OPI, MFCU or as ordered by a court;¶
(ff) Fails to report to Authority or ODHS payments received from any other source after the Authority made payment for the service;¶
(gg) Fails to comply with federal or state statutes and regulations or policies of the Authority or ODHS that are applicable to the provider;¶
(hh) Fails to obtain or maintain required provider credentials or has credentials suspended or otherwise revoked by the credentialing entity, for any reason;¶
(ii) Fails to correct subcontractor deficiencies in operations or non-compliance with Medicaid program requirements after receiving written notice of the deficiencies from the Authority;¶
(jj) Acts to discriminate among members on the basis of their health status or need for health care services, or on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability; violates member civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A;¶
(kk) When a person with five (5) percent or more direct or indirect ownership interest in the provider, or an agent, affiliate, supplier or managing employee of the provider is found to be in violation, independently or in tandem with the provider, of one or more of the provision of section (4) or (5) of this rule;¶
(LL) When a MCE participating provider or subcontractor enrolled or seeking enrollment as an encounter only provider is found to be in violation of one or more of the provision of section (4) or (5) of this rule;¶
(mm) Submits a bill or invoice or otherwise seeks payment from a member for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by OAR 410-120-1280. If the member was eligible for medical assistance on the date of service, and the provider does not have a completed signed agreement to pay form (3165, 3166), the provider is not allowed to bill the member, collect payment from the member, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS 414.066, except as authorized by section (5) of OAR 410-120-1280. The Authority sanction of the provider may include but is not limited to any amount necessary to fully repay the member for the billed services, fines, fees or other financial penalties imposed on the member by the provider or any third party collections agency, and any accrued interest.¶
(nn) Failure to comply with Authority or its designee's notice that the provider is in violation of ORS 414.066 within 30 days or within the time required in the Authority's written notice;¶
(oo) Failure to comply with federal or state statutes and regulations or policies of the Authority that are applicable to the provider;¶
(pp) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;¶
(~~5~~6) A provider excluded, suspended, or terminated from participation in a federal or state medical program, such as Medicare or Medicaid or CHIP, or whose license or certification to practice is suspended or revoked by a state licensing board or Authority may not submit ~~claims~~encounters or claims to the Authority for payment, either personally or through claims submitted by any billing agent/service, billing provider, or other provider for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension, or termination; unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23.¶
(~~6~~7) A Provider~~s~~ may not submit encounters or claims for payment to the ~~Division~~Authority for payment for any services or supplies provided by an individual provider or provider entity that is excluded, suspended, or terminated from participation in a federal or state medical program or whose license to practice is suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension, or termination; unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23.¶
(~~7~~8) When any one of the provisions of sections (~~5~~4) or (~~6~~5) of this rule are violated, the ~~Division may~~Authority may suspend or terminate the billing provider's enrollment agreement or the enrollment agreement of any individual provider who is in violation. When a provider is sanctioned, all other enrolled providers in which the sanctioned provider has ownership or controlling interest of five (5) percent or greater, may also be sanctioned and suspended or terminate ~~the billing~~d.¶
(9) When any of the provisions of section (4) are violated, Authority shall withhold and recover all payments made to the provider for ~~any individual performing provider within said organization who is responsible for the violation~~services furnished after the effective date of the sanction; unless good cause not to recover payments exists, in accordance with 42 CFR §455.23. When provisions of section (5) are violated, Authority may withhold and recover all payments made to the provider for services furnished after the effective date of the sanction.¶
(10) When a provider sanctioned as a result of exclusion from participation in federal or another state's health care programs the scope of the provider appeal of the Authority's Action is limited to a review of whether the

provider was, in fact, terminated by the initiating program. The appeal will not review the underlying reasons for the initiating termination. The provider must contact the federal or state agency which issued the initial decision.¶
(11) Authority shall, for any provider or any person with a relationship with the provider who meets the circumstances for exclusion listed in 42 CFR 1001.1001, promptly notify the OIG of any action(s) Authority takes on the provider's application for enrollment in the program and any action(s) taken to limit the ability of a provider, whether an individual or entity, to participate in Oregon's Medicaid program, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where the provider voluntarily withdraws from the program to avoid formal sanction(s).¶
(12) Authority shall, for any provider sanctioned by the Authority under this rule 410-120-1400 list the name(s) of the provider, NPI, duration and the effective date of the sanction on the Authority's website.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ~~ORS 414.019,~~ 414.025, 414.065