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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 24-2026

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

FILED: 06/24/2026 11:14 AM
ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

FILING CAPTION: Allowing Caring Contacts to be a Medicaid covered service as part of suicide prevention efforts.

EFFECTIVE DATE: 07/01/2026 THROUGH 12/27/2026

AGENCY APPROVED DATE: 05/29/2026

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NEED FOR THE RULE(S):

Rule 410-125-0045: The proposed change made to this rule is to add “Caring Contacts” as an exception to services which

are provided outside of the hospital’s licensed facilities but can be covered by the Division as hospital services. This change is needed in order to allow Caring Contacts to be a covered service and allow providers to bill for such services.

Rule 410-125-0220: The proposed change made to this rule is to describe “Caring Contacts” as a service provided by a hospital or hospital employees and how billing claims to Medicaid will be made for these services. In order to allow Caring Contacts to bill billed for, this change, in addition to the one above, will need to be in place.

JUSTIFICATION OF TEMPORARY FILING:

(1) Describe the specific consequences that result from the failure to immediately adopt, amend or suspend the rule(s):
These are vital services that are required by law for people experiencing a suicide crisis. People in Oregon discharging from the Emergency Department for a behavioral health crisis need the evidence-based intervention

of caring contacts to support them and it is required for hospitals to provide. Hospitals have identified struggles to provide this service due to lack of reimbursement which is required by HB 3091 (2017). We need to act with urgency so that care does not continue to be delayed to patients that need this intervention. The billing pathway this rulemaking will create is needed now so that people get needed care right away.
(2) Who would suffer these consequences:
Any person in Oregon who has experienced a behavioral health crisis and presents to an Emergency Department for support.
(3) Why or how failure to immediately take rulemaking action would cause these consequences:
Care will continue to be delayed for those being discharged from an Emergency Department for a suicide crisis and their future risk for suicide may be increased.
(4) How the temporary action will avoid or mitigate those consequences:
The billing pathway this rulemaking will create is needed and will allow this care to be provided to people who have experienced a behavioral health crisis.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Emergency Department Discharge Practices for Behavioral Health Crisis Care: A Statewide Survey of Hospitals: [https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4272.pdf]
This OHA report published in July 2022 is based on surveys with hospitals related to implementation of ED discharge practices required for an individual who presents with a behavioral health crisis. Almost half of hospitals indicated they did not know about or are receiving reimbursement for services required by HB 3090/3091 (2017) including caring contacts.

RULES:
410-125-0045, 410-125-0220

AMEND: 410-125-0045

RULE SUMMARY: Amending section 5, adding Caring Contacts as an exception to services provided outside the hospital's licensed facility that can be covered by Medicaid as hospital services.

CHANGES TO RULE:

410-125-0045
Coverage and Limitations ¶

In general, most medically necessary and appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the ~~Division of Medical Assistance Programs' (Division) General Rules Program~~Oregon Administrative Rules (OAR) in Chapter 410, Division 120 and the Oregon Health Authority's (Authority) other Medical Assistance OARs found in Chapter 410 for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are: ¶
(1) Prior authorization (PA): Some services require PA for the Oregon Health Plan (OHP) Plus Benefit Package ~~check~~. In order to determine which services require PA for the OHP Plus Benefit Package, refer to OAR 410-125-0080. ¶
(2) Non-covered services: ¶
(a) Services that are not medically necessary and appropriate, unproven medical efficacy or services that are the responsibility of another Department of Human Services (Department) or Oregon Health Authority (Authority) ~~Division~~ are not covered by the ~~Division of~~Authority's Medical Assistance Programs; ¶
(b) Service coverage is based on the Health Evidence Review Commission's (HERC) Prioritized List of Services and the client's benefit package; ¶
(c) See the ~~G~~general ~~R~~rules for the Authority's Medical Assistance Programs (chapter 410, division 120) and other program divisions in chapter 410 for a list of services that are not covered ~~services~~. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

on the Oregon Health Authority's Health Systems Division's webpage. ¶
(3) Limitations on hospital benefit days: Clients have no hospital benefit day limitations for treatment of covered services. ¶
(4) Dental services: Clients have dental/denturist services identified as covered on the HERC Prioritized List (OAR 410-141-5223-1260). ¶
(5) SHospital services provided outside of the hospital's licensed facilities; for example,: ¶
(a) Services provided in the client's home or in a nursing home, are not covered by Divisionthe Authority as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services; ¶
(b) There are a limited number of hospital services that are covered when they are provided during a ground or air ambulance transport.outside a hospital's licensed facility, which include the following: ¶
(6A) Dialysis services require a written physician prescription. The prescription must indicate the ICD-10 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules ProgramCaring Contacts services (described in OAR 333-520-0700); ¶
(B) Maternity Case Management services (described in OAR 410-130-0595); and ¶
(C) Specific nursing or physician services provided during a ground or air ambulance transport (described in OAR 410-136-3180).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0220

RULE SUMMARY: Adding section 13, which adds Caring Contacts as a service hospitals can bill for using the electronic 8371 or paper CMS 1450 (UB-40) claim form.

CHANGES TO RULE:

410-125-0220
Services Billed on the Electronic 837I or on the Paper UB-04 and Other Claim Forms ¶

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-04) claim form. ¶
(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-04) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost. ¶
(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by the ~~Division of Medical Assistance Programs (Division) through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may~~Oregon Health Authority in accordance with the medical education reimbursement rates identified in OAR 410-125-0141 so long as the hospital where the residents and medical students work qualify for those payments. The services provided by residents and medical students that are paid the rates identified in OAR 410-125-0141 must not be billed on the electronic 837I or paper CMS 1450 (UB-04). ¶
(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper CMS 1450 (UB-04) claim: ¶
(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. The Division will not reimburse the other provider or hospital; and ¶
(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. The Division will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-04). ¶
(5) Orthotics, prosthetics, durable medical equipment and implants: ¶
(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper CMS 1450 (UB-04), along with all other inpatient services. The hospital is responsible for reimbursing the provider. The Division will not reimburse the provider; ¶
(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the durable medical equipment supplier or by the hospital if the hospital is the supplier. ¶
(6) Pharmaceutical and home parenteral/enteral services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-04, except home parenteral and enteral services and medications provided to patients who are in nursing homes: ¶
(a) Home parenteral and enteral services, including home hyperalimentation, Home IV antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral Program rules (chapter 410, division 148); ¶
(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services Program rules (chapter 410, division 121). ¶
(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-04). For hospital dentistry requirements refer to the Dental Service Program rules (chapter 410, division 123). ¶
(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-04) as described in these rules and instructions and will be reimbursed at the hospital's interim rate. ¶
(9) Maternity case management: ¶
(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical Program rules (chapter 410, division 130) contain information on the scope of services, definition of program terms, procedure

codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-04); and ¶
(b) Providers must bill using Revenue Code 569. ¶
(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Division's Home Health Care Services Program rules (chapter 410, division 127). ¶
(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to the Division for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. The Division will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation Program rules (chapter 410, division 136). ¶
(12) Supervising physicians providing services in a teaching setting: ¶
(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-04) with other inpatient or outpatient charges only when: ¶
(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and ¶
(B) The hospital does not report these services as a direct medical education cost on the Medicare and the Division's cost report. ¶
(b) The services of supervising faculty physicians are not to be billed to the Division on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-04) if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and the Division's cost report; and ¶
(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410, division 130) for additional information on billing on the electronic 837P or the paper CMS-1500. ¶
(13) Caring Contacts services in a hospital setting: Caring contacts services are provided to clients as described in OAR 333-520-0070. ¶
(a) For purposes of billing under this rule, the caring contact must: ¶
(A) Be made within 48 hours after a patient has been discharged from a hospital after presenting to the Emergency Department with a behavioral health crisis (as defined by ORS 441.053); and ¶
(B) A qualified mental health professional or a registered nurse meeting the competency and training requirements identified in 333-520-0070(4)(g)(A) determined the patient's behavioral health crisis involved attempted suicide or an experience of suicidal ideation. ¶
(b) The hospital may: ¶
(A) Provide the caring contacts services in person, by phone, or via telehealth; ¶
(B) Contract with a qualified community based behavioral health provider for the provision of these services; or ¶
(C) Contract with a suicide prevention hotline for the provision of the services. ¶
(c) These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-04). ¶
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065